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Including Syphilis

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THE JOURNAL OF CUTANEOUS DISEASES

VOL. XXXVI—No. 4 APRIL, 1918 WHOLE No. 425

Original Communications

AN ERUPTION OF ACUMINATE PAPULES IN ACUTE LICHEN PLANUS*

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AND

GEORGE D. CULVER, M.D.

SAN FRANCISCO

Lichen planus is a symptomatic disease, that is to say, it is a disease in which the cause is unknown. It is only recognized by the symptoms which a hypothetic cause evokes. Under such circumstances narrowness of definition as to what constitutes admissible symptoms is of great value, as otherwise the definiteness of the clinical picture tends to become blurred. Lichen planus is preëminently a papular disease, and the typical lichen papule is delightfully characteristic. It is small pinhead sized, with an angular base and a flattened top. There is frequently on the top a minute depression — an umbilication. The papule gives an impression of substantiality, which it really possesses, as it is composed of a tightly packed, well circumscribed infiltration of small round cells in the papillary layer of the skin. The top of the papule is smooth or is covered by a delicate scale, and in oblique light it glitters like glass or like smooth wax. The red color of the papules as a group is also peculiar, as it frequently has a violet tint. Frequently they are aggregated into groups, and very frequently indeed they are itchy. That in almost all cases the papules of lichen planus are really planus or flat topped there is no question. The question is, can some of the papules be acuminate? Or, at one stage in some cases may all of the papules be acuminate?

Darier says that in some cases of acute or subacute lichen planus a few acuminate papules will be found, and Jadassohn[1] remarks, in an

* Received for publication September, 1917.

1. Dermatologie von J. Darier, 1913, pp. 91 and 92. Translated by Dr. Karl Z. Zwick and annotated by Prof. Dr. J. Jadassohn.

annotation, that the acuminate papules are due to the particular lesion having a follicular localization. In the present instance all of the papules, irrespective of any follicular localization, were at first acuminate with the exception of those on the back of the hands. They later changed from the acuminate to the typical planus type.

It appears that T. C. Fox, Crocker and others have described a form of lichen planus occurring in children in which the papules are at first acuminate, and later become flattened. It is said to itch severely. The eruption comes out suddenly, and may be made to disappear quickly under soothing applications.[2]

This description fits more nearly the state of affairs in the present case. The patient, however, was not a child, but an adult, and the eruption evoluted more slowly than the above description would indicate, as it occupied the usual time, about five months, for an acute lichen planus eruption to disappear.

REPORT OF CASE

Oct. 12, 1916, a short, stout man, aged 50, called on us on account of an eruption which he had first noticed a few days previously. There were a vast number of papules on the back across the shoulders. These he said were at first not red, but became reddened later, and when we first saw him, were slightly so. The papules were small, even in size, prominent, acuminate, discrete and they were arranged in a distinct but not very regular network. The papules were not desquamative and although they glittered in oblique light, the glitter was not the characteristic waxy or vitreous glitter of lichen planus. There were some red acuminate papules on the front of the wrists, and there were some flattened but not absolutely characteristic papules on the backs of the hands. These resembled the flattened, red, seborrheic patches that not infrequently arise in this region. Granting them to be seborrheic patches they were unusually numerous. There were some papules also in a brown field on the back of the neck against which the base of the collar button rested. At each side of the base of the neck there was a brown desquamating streak running anteroposteriorly, in which there were some acuminate papules. There was no itching. There was no eruption in the scalp, on the face, on the lower extremities or on the penis. There was a white thickened patch, about 2 by 4 mm., on the left side of the tongue. The cheek pouches were clear of trouble.

Our suspicions of the eruption being lichen were aroused by the thickened lingual patch, by the brown, desquamating streaks at the base of the neck, and very especially by the reticulated arrangement of the papules on the back across the shoulders.

In a week the patient called again, and the eruption was much better, but was more typical of lichen planus. The isolation of each papule, their retiform arrangement, their glitter and their substantiality all reminded one of a lichen eruption. In one instance a papule was umbilicated, and many of them had a little desquamation at the apex.

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2. Hardaway and Grindon: Cutaneous Therapeutics. Philadelphia, Lea & Febiger, 1907, p. 167.

The eruption of the backs of the hands had almost entirely cleared off, showing that they were not seborrheic patches, which evolute with extreme slowness. The condition in the mouth was most interesting. The white patch on the left side of the tongue had disappeared, but eruptions had appeared in the cheek pouches. In the left cheek pouch there was an area with characteristic lacework and distinct papules, and there was a white plaque in the right cheek pouch.

October 27, fifteen days after we first saw the patient, there was an irregular group of papules on the left side of the tongue, and what appeared to be two small papules on the right border of the tongue. The papulation and lacework in both cheek pouches was now beautifully distinctive of lichen planus, and there were some lichen planus papules on the glans penis. There were some very small, typical lichen papules on the abdomen, especially in the flanks. In the axillae there were some large, dull red, prominent rounded papules, about 3 mm. in diameter, which itched a little, and this was the only situation in which the patient had any irritation at all.

The few remaining papules on the backs of his hands were flattening out, and when looked at directly, appeared like a simple redness. By reflected light, however, the glittering facets could be seen.

Subsequent to this the eruption flattened out into typical lichen papules and finally disappeared, leaving the usual brown stains. In January, a raised ring with a brown center persisted on the back, and there was a little opalescence of the mucous membrane just inside the right angle of the mouth. In April, that is, about five months from our first observation of the patient, almost all evidence of the eruption had disappeared.

It may be that acute lichen planus occurs as an acuminate papular eruption more frequently than is supposed. Acute lichen planus is not frequent and most of the cases in their early stages would naturally be seen by the general practitioner. It so happens that the status of this disease in the profession is a peculiar one, as the dermatologists are the only physicians who take the slightest interest in its morphology. By the time such a case reaches the specialist the acuminate papules may have changed into planus.

There was no question in this case of the presence of pityriasis rubra pilaris with which lichen planus has sometimes been confused, nor of lichen pilaris which is more a deformity than a disease. It is because of the incident confusion that the term lichen plano-pilaris is particularly condemnable.

ULCERATING GRANULOMA OF THE PUDENDA*

REPORT OF TWC CASES

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Ulcerating granuloma of the pudenda, also known under the names of granuloma venereum, groin ulceration, granuloma inguinale tropicum, etc., is a chronic, infective disease produced by a micro-organism described by Donovan under the name of *Calimatobacterium granulomatis.*

This rare condition, usually found in dark-skinned races, was first described as a clinical entity by Conyers and Daniels, who placed it in a common group with the so-called tropical ulcers, but its true nature was not disclosed before the investigations of Donovan and the South American dermatologists, Souza of Brazil among them.

The malady begins insidiously on the genitalia (scrotum, penis, or vulva) as a small, moist papule which after some time breaks down, forming a small ulceration which, growing excentrically, invades and destroys the surrounding parts; sometimes a small pinhead to pea-sized prominence follows the primary manifestation, thus constituting the papillomatous type of the disease; sometimes both papillomas and ulceration are combined, forming the mixed type.

Cases have been recorded of extragenital lesions, but they seem to be very uncommon. The disease has no relation whatever to syphilis, chancroid or blennorrhagia. The mode of contagion appears to be by sexual intercourse, although several cases have occurred in children under puberty. Uncleanliness is a great factor in contracting the disease.

I have recently had occasion to study two cases of this disease.

REPORT OF CASES

CASE 1.—*History.*—Maria C., a mulatto woman from Santa Clara province, Cuba, aged 24, married, was admitted to the Mercedes Hospital, Nov. 20, 1914.

Her past history is negative; both parents died from "fever" during the Cuban independence war; she has one brother, living and healthy; she has had no children, and her husband is a healthy and strong young negro. No history of syphilis could be elicited; the patient declares she had malaria and measles during her childhood, but no other disease afterward. The present ailment began five years ago, as a small sore on the right labium marjorum, which in the course of several months gave place to an ulceration about the size of a dime;

* Received for publication Sept. 15, 1917.

this increased slowly in all directions and invaded the groin of that side and part of the gluteal region, wherefrom it spread to the perineum and labium and groin of the other side.

Ulcerating granuloma in a young mulatto woman. The ulcero-papillomatous process in spreading has destroyed both labia majora and minora with the exception of a small area on the left. The ulcerating surface is raised, sharply defined and hard.

Examination.—At the time of examination the following condition was observed: an extensive, ulceropapillomatous surface affecting the genitals; both labia majora and minora were missing, excepting a small area of the left side as shown in the accompanying illustration; the vulva was represented by an irregular orifice, and the anus was surrounded by a papillomatous growth; this surface was covered by thick, yellowish pus of peculiar offensive odor.

The edges of the ulceration were raised, sharply defined, rather irregular and hard. The neighboring glands were somewhat enlarged. The patient complained of lancinating pains, especially at night. The Wassermann test was negative. The urinalysis revealed no abnormality.

Histopathology.—Specimens for microscopic study were taken from the pus, and a small papillomatous tumor was excised for examination. At the time of this observation I did not know of the existence of the *Calimatobacterium granulomatis,* and therefore I could only detect in the secretion numerous cocci and bacilli without anything especially characteristic; no spirilla or treponemes were found. The pathologic changes were those of chronic inflammation: round-cell proliferation, papillary elongation, and dilatation of the vessels; numerous plasma-cells could be seen around the latter.

TREATMENT

This patient was given three injections of salvarsan and a dressing saturated with a solution of potassium permanganate in the proportion of 1 : 1,000 applied locally. After a month's treatment the local condition had not changed, although the lesions were cleaner and the discharge was not so offensive. Then I began to treat the patient according to the method of the South American dermatologists, namely, 5 c.c. of a solution of potassium and antimonium tartrate (1 per cent.) were injected intravenously every other day. The first treatment was followed by slight malaise and nausea, but the other injections were devoid of any untoward consequences. Improvement was noted after the fourth treatment, when the ulcerated part at the groins began to heal, forming a white, raised and retracted scar. Cicatrization then took place slowly, and after five months the patient was almost cured; only two areas remained active, one around the anus and the other around the vaginal orifice. The patient left the hospital and she passed from further observation.

CASE 2.—*History.*—Manuel P., white, aged 25, by occupation a teamster, born in Havana, entered the Mercedes Hospital, March 6, 1917.

His father died of an unknown disease; the mother is still living and is healthy; there are eight healthy brothers; one sister died of tuberculosis of the lungs. The patient never had syphilis nor blennorrhagia; seven months ago he had two chancroids which disappeared under local treatment. His digestive, respiratory, circulatory and nervous systems were normal; the Wassermann test was negative. The actual disease began ten years ago, when two small nodules appeared on the lower part of the scrotum, remaining for several months; then gradually they became exulcerated, and several small, irregular prominences of papillomatous aspect, arose in situ. The disease affected the rest of the scrotum progressively, later invading the penis in all its length.

Examination.—There were at the time of examination between fifty and sixty papillomas of about the size of a pea to a filbert, secreting pus of offensive odor, mixed with blood. The patient complained of itching and burning sensations.

MICROSCOPIC FINDINGS

In the specimen I could detect the specific germ; it is a short, capsulated bacillus, disposed in long chains; it is easily distinguished from the other bacteria on account of its wide, clear capsule; the best stain

is Giemsa. I could not obtain a pure culture of this micro-organism, but it was still present in agar mediums, together with many other bacteria. The patient refused to give the writer permission to obtain a specimen for a biopsy or a photograph of the lesion.

TREATMENT

The patient was given one intravenous injection of 5 c.c. of a 1 per cent. solution of potassium and antimonium tartrate and left the hospital refusing further treatment.

Although these are the first two cases recorded in our country, I believe that the disease is not uncommon; I am told by physicians practicing in country districts that they have observed similar cases, especially in the eastern part of the island.

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A CASE OF SCLERODERMA DIFFUSA IN A GIRL, NINE YEARS OF AGE*

WITH A REVIEW OF THE LITERATURE

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Sclerodermatous conditions are classically divided into three main groups: (1) the generalized or diffuse; (2) the localized or morphea type, and (3) sclerodactylia. A special subdivision of localized scleroderma is the peculiar lichenoid form, recently studied by Wise and Rosen.[1] Both first mentioned divisions are recognized to pass through three stages in their evolution, and the textbooks describe the edematous, the infiltrated and the atrophic stages. The age periods have given rise to further divisions, and we have sclerema neonatorum (probably not a sclerodermatous condition at all) and the diffuse scleroderma of children and of adults. The onset determines whether the qualifying adjective — acute — should be appended.

The infrequency with which the acute form of diffuse scleroderma is encountered in children and the great difficulty in determining tangible etiologic factors in the causation of the malady, are deemed of sufficient interest to justify the writer in recording the following case, observed in the service of Dr. Longcope at the Presbyterian Hospital.

Report of Case

The patient is a white girl, 9 years old. Her family history has little direct bearing on the case. The parents are well; there are three sisters, living and healthy. There was one miscarriage among her mother's pregnancies.

Personal History.—She is a school girl, a good student, lives at home in good sanitary surroundings, and takes plenty of exercise. In early infancy, at the age of 7 months, the child was operated on for an intestinal trouble. The symptoms were vomiting and cramps; the diagnosis is not known. At 6½ years, she had measles and made a good recovery. Each winter the child has had frequent, transient sore throat. There have been no other illnesses.

Present Illness.—Seven weeks prior to admission, the patient had an attack of her winter sore throat. There was slight fever, but no chills, vomiting, headache or pains in the extremities; the child was given a mouth wash, and the back of her neck was painted with iodin. She was in bed four days. There were no cutaneous or cardiac symptoms during the illness, which lasted ten days.

Three weeks prior to admission, the mother noticed that the girl's jaws did not open as far as usual, and several days after, while combing the child's

* Received for publication Oct. 10, 1917.

1. Wise and Rosen: Jour. Cutan. Dis., February, 1917.

hair she observed that the head did not extend as much as normally. The local physician was consulted and found stiffness of the skin of the neck, posteriorly and anteriorly, and of the scalp, forehead, cheeks, forearms and thighs. He prescribed hot oil rubs for the skin, and rest in bed, because her heart was enlarged and beating too fast. The child always felt well.

Physical Examination.—The general appearance gives one the impression of dulness, which her manifest interest and intelligent conversation belie. The face looks puffed and doughy. The head is symmetrical. There is no mastoid tenderness nor discharge from the ears or nose. The eyes are half closed by the immobility of the thickened lids. The conjunctivae are clear, the pupils central, equal and react to light and accommodation. The mouth can be only partly opened; the lips are soft and moist, and the tongue is hard and cannot be protruded. The pillars are only slightly stiff; the soft palate is free, and the tonsils are of the buried type with nothing abnormal about them. The teeth are in good condition.

The lungs are clear throughout. Expansion of the chest is equal and fair.

The heart presents a diffuse apex beat, visible in the fourth and fifth space, 7 or 8 cm. to the left of the midline. There is dulness on percussion in the second space, 2 cm.; third space, 5 cm.; fourth space, 9.5 cm.; fifth space, 8 cm. The right border is at about the right sternal margin. The first sound at the apex is loud and of good muscular quality; second sound is also loud. Action is rapid and overactive. At the base, the aortic second sound is greater than the pulmonic second and somewhat accentuated. There are no murmurs. The pulses are equal, regular, rapid, full, soft, and of moderate force. The abdomen is soft, there is no tenderness, no rigidity, no masses are felt, and there is no free fluid. Liver dulness is present in the fourth space and flatness in the sixth space; the lower edge of the liver is not palpable. The spleen and kidneys are not felt. The reflexes are all normal.

On admission, the pulse was 120. It ranged during the first week between 140 and 110, falling only on one occasion to 92. During the second and third week of her stay in the hospital, the variations were only 5 above or below a mean pulse rate of 95, with 110 as high and 80 as the low mark.

The temperature curve has never followed the pulse rate, seldom falling below or going above 99 F.

The respirations have varied between 24 and 32.

The weight remained the same, 52 pounds.

The blood pressure was difficult to determine accurately because of the hardness of the skin. On one occasion the systolic pressure was recorded as 110, diastolic, 60.

Blood.—Red blood cells, 4,629,000; hemoglobin, 95 per cent. (Sahli); white blood cells, 9,000; polymorphonuclears, 43; lymphocytes, 53; large mononuclears, 1; transitionals, 2; basophil, 1; smear, normal.

The blood Wassermann on the child gave a doubtful reaction to the alcoholic antigen, and a ++ with the cholesterin reinforced. A blood Wassermann on the mother was negative with both antigens. The child showed no stigmata of hereditary syphilis.

Urinalysis.—The urine showed a very faint trace of albumin, occasional hyaline casts and rare granular casts on two examinations. There was no reduction of Fehling's solution.

Skin.—The skin of the forehead, scalp, back of the neck and shoulders, as low as the spines of the scapulae, the cheeks, the chin and the neck as far down as the clavicles, is most markedly affected. The skin of the upper arms and lower legs are less affected; the forearms, thighs, back, chest and abdomen still less. The ears, alae nasi, the hands and feet and a narrow area around the mouth are least changed.

The hair of the scalp is fairly profuse and well distributed. The eyelids droop, appear stiff and give the child an inattentive and stupid expression.

There are no wrinkles. The face is freckled. The extensor surfaces of the forearms and lower legs have a sparse growth of lanugo hairs; both forearms present several small, spider nevi. The affected portions of skin are erythematous; the skin over the thyroid is most reddened. The erythema disappears on pressure but rapidly returns. The skin is glossy. There is no evidence of perspiration except in the axillae and palms.

The skin is warm and dry. It feels thickened, but inelastic, and has a boardlike hardness. It is not possible to pinch up any skin between the thumb and forefinger. There is no pitting on pressure.

The forehead cannot be wrinkled; nor can the lower lids be retracted downward. The mouth can be opened only partly—the greatest distance between the upper and lower incisors is 2 cm. The child is unable to whistle, and smiling is a conscious effort with no response on the part of the facial expression. Active and passive movements of the head, extension, flexion, lateral flexion and rotation are limited. Extension at the elbows is impossible beyond 175 degrees. The movement of no other joint is embarrassed. The tongue can be protruded only 1 cm. beyond the lips. It is hard, nonflexible and seems contracted.

There is a laparotomy scar in the midline for 3 inches above the umbilicus. On the right buttock is a pigmented, nonelevated nevus, about 4 by 10 cm.

CLINICAL COURSE AND TREATMENT

During her stay in the hospital the child was cheerful and happy. She spent the day in bed, playing with her doll, learning to knit, writing to her friends, and cutting out paper clothes. On being transferred to another ward, she cried for one afternoon because of her strange surroundings. Each day she would report that some part of her body felt a little softer, that she could open her mouth a little wider, or straighten out her elbow to a greater extent.

Oil rubs were given during the second and third weeks in the hospital by a professional masseuse, with only transient, if any, improvement. Thyroid extract in daily, half-grain doses, was also administered for several weeks. There was no effect either on the heart rate or on the cutaneous condition. After a month in the hospital the child was discharged unimproved, but was advised to continue the oil rubs and the thyroid. Although given a return date for further observation, the mother had not brought the child to the dispensary, until visited by a social service nurse.

Five months after her entrance into the hospital she was visited at her home. The child's general appearance had changed considerably. She looked bright, and recognized at once the caller she had not seen for four months. Her face was apparently much thinner, but there was no swelling present. The skin of the scalp retained its hardness and immobility, but the eyelids and cheeks were soft and pliable. The tongue was protruded between lips that opened widely. No tremor was present.

The heart retained its borders but the rate was reduced to 80. The rhythm was regular, and the force moderate. The lungs and abdomen remained as before.

Except for the scalp, the hardness of the skin was gone. Here it was still impossible to pinch a part up between the fingers, or to slide it on the skull. The back of the neck and the thighs still gave an increased resistance to pressure, but was not thickened nor hard. The erythema formerly so marked was not present. The elbows were readily extended to the normal limit. The patient's weight remained at 52 pounds.

It is noteworthy that neither the primary stage of edema nor the final stage of atrophy have been observed in this child.

REVIEW OF THE LITERATURE

A hasty survey of the literature has revealed only three recent cases of diffuse scleroderma in children.

CASE 1.—(Lewin and Heller, Case 294). *RADCLIFFE CROCKER* (*Brit. Med. Jour.*, 1878). Summarized in Crocker's Diseases of the Skin, 1888, p. 314.

"In a child of 12 who came under my care, through the kindness of my colleague, Dr. Eustace Smith, the whole body surface was involved except the palms and soles, within a fortnight, and there was endocarditis and pericarditis; yet, within three weeks some diminution of the induration set in, though it was twelve months before the child was quite well. Many run a course much slower than this."

Crocker precedes this notation of an instance of diffuse scleroderma in a child, by the following remarks:

"Although the name adultorum has been appended in contradistinction to sclerema infantum, with which it has no connection, scleroderma frequently occurs in children and bears the same character among them, except that it tends to run a more acute course both in onset and termination, while the atrophic phase is less often developed."

From the literature of the subject, it is to be inferred that scleroderma occurs infrequently in children. This is especially true of the acute diffuse form, of which the subject of this report is an example.

The acute character of the affection in children is relative only; in adults it is more insidious and persistent. The stage of infiltration, however, is of longer duration in adults.

CASE 2.—*OSLER*, in his monograph on the use of thyroid in scleroderma, mentions a case of Marsh (*Med. News*, London, 66), of scleroderma which followed diphtheria in a child, aged 2 years. The condition was quite extensive. Dr. Marsh wrote, Dec. 29, 1897, that "the child has recovered completely and showed no trace of the disease."

Following the report, Osler raises the question whether the case was one of diffuse scleroderma or whether it was not one of acute sclerema of the same nature as sclerema neonatorum, following diphtheria. The whole process was very acute, extending from its inception to complete cure, over a period of only four months.

CASE 3.—*BRAYTON*, during a discussion by Dr. Ravogli on "Rare Forms of Scleroderma" (*Jour. Cutan. Dis.*, 1917, 35, p. 9), mentions the following case of acute diffuse scleroderma following tonsillar infection:

"Very notable was the case of a girl, 8 years old, suffering from tonsillar infection and three weeks' resulting fever. During this time the skin became so hardened from the scalp to the toes that it was impossible to pinch it up in any portion of the body. Her appetite was immense as she convalesced, eating four or five meals a day and active in playing about the hospital grounds.

After three months, resolution began and her condition is normal by the end of five or six months. The patient was found healthy four months after her recovery."

This case is for age, sex, possible causation, temperature, acuteness, extent and course, almost a replica of the child here reported.

Eighty-eight of the 505 cases gathered by Lewin and Heller in their monograph, "Die Sclerodermie," occurred in children from birth to 19 years, inclusive. The great majority were cases of circumscribed scleroderma. Of the diffuse scleroderma, other than of the new-born, but twelve were of the acute form. Cases of diffuse scleroderma with gradual and insidious course, are probably examples of the circumscribed form, presenting a coalescence of contiguous patches.

The earliest case report, according to Crocker, is the following:

CASE. 4.—(Lewin and Heller, 23). *CURZIO*: Diss. anatom. et pratiq. sur une maladie de la peau espece fort rare et fort singuliere, Paris, 1752, letter to Abbe Nollet, 1754, published by Gintroc (*Jour. d. méd. de Bordeaux,* 1874). The author describes a case in a girl, 17 years old, in whom the skin of the entire body was hard. In some places, as on the neck and forehead, the induration was especially marked. The tongue was very hard, and could not be protruded. Deglutition and speech were interfered with. The mouth and eyelids could not be opened widely. On each side of the linea alba was an indurated area 4 inches wide. The affection began at the neck. The temperature was low. The secretion of sweat almost nil. Other findings were negative.

CASE 5.—(Lewin and Heller, 189). *BARMANN:* Inaug. Diss., Berlin, 1825. The child, a boy, 6½ years old, had headache following a cold, loss of appetite, and pain and stiffness of the neck. The skin of the face, hands and legs was hard and cold. There was no perspiration. The skin of the body, except for the genitals, was swollen, yellowish white, fixed to the underlying parts, impossible to crease, and almost ice cold. There was marked sclerosis of the underlying parts. The palms and soles, and the under surface of the legs and abdomen were less hard. The author says a tuberculous diathesis and the "cold" infection were the cause of this chronic hardening of the tissues. Improvement followed treatment. The face and neck remained somewhat hardened.

CASE 6.—(Lewin and Heller, 28). *THIRIAL* (*Jour. de méd.,* 1845); from *Würzl. med. Ztschr.,* 2, p. 215. A girl, aged 15, had amenorrhea after washing clothes in cold water, and immediately afterward felt that her neck was stiff. Within a week the entire upper portion of her body was affected. The skin of the side of the neck, the nape of the neck and the back were so stiffened that it could not be impressed with finger pressure. All the normal folds were obliterated, and the skin was so incorporated with the underlying structures that the movements of the larynx and the eyelids were rendered difficult. The color of the skin was normal, but the neck was slightly erythematous. The sensation of the skin, and the sweat functions were normal.

CASE 7.—(Lewin and Heller, 34). *RILLIET* (*Rev. méd. chir.,* February, 1848). The patient was a girl, 9 years old. The illness began five days prior to the day on which she was first observed, with stiffness of the neck, sudden pains in the epigastrium, and palpitation of the heart. There was a painful area of the skin in the epigastric region which was hard, resistant, cold and without creases. The following day, there was hardening of the entire body. The muscles and joints were not affected; only the skin and cellular tissue. The induration lasted eight or ten days and then gradually faded. Little skin remained affected. The eyelids were free, but the tongue remained thickened. The sensation was normal; the respiration was increased, and there was accleration of the pulse. Besides the skin sclerosis, there were ascites, hydropericarditis, and right-sided pleuritic exudation.

CASE 8.—(Lewin and Heller, 16). *GILLETTE* (*Arch. gén. de méd,* 1854). In a healthy child, 8½ years old, following a cold, the scleroderma began on the neck. There was rapid spread. The head, trunk and upper extremities soon presented skin that was definitely hard, and felt like gutta-percha. The hardened skin was immobile over the underlying structures. The face was motionless; the eyelids were half closed, and the nares were drawn together a little. The forearms were half flexed and the arms were abducted a little from the sides. One could not observe a fold in any affected portion, nor could one be produced. The face was most markedly affected. After two months, movements at the joints were easier. The cure became apparently complete, only the skin felt more resistant than normal. There was a mild sclerodactylia. The function of the skin was normal.

CASE 9.—(Lewin and Heller, 42). *KOEHLER:* Zur Lehre von der sogenannten einfacher Hautverhärtung (*Württemb. Cor.-Bl.,* 32, 1862). From *Schmidt's Jahrb.,* vol. 118. A girl, 12 years old, of good ancestry, came to the clinic in 1860 with acute laryngeal and bronchial catarrh, and a mitral insufficiency. These responded to treatment. The child returned in October, 1861, complaining of palpitation of the heart and a stiff neck. At first, there was a nonpainful inelasticity of the skin of the neck so that the head could only be flexed and extended slowly. The face was rotated a little to the left. There was stiffness of the upper lids so that they could not be closed. Several days later, during a sudden rise in temperature, the face, neck and extremities were involved. There was thickening of the subcutaneous fibrous layers, and the thickness of the skin became decreased in isolated patches.

In certain localities, the healthy and affected skin areas were sharply marginated. The head moved with difficulty. The eyelids could open only 1 cm. The movements of the tongue were slow. Chewing and swallowing were difficult. The face was masklike in appearance. The arms were slightly flexed at the elbows. The hands were held on the chest or on the epigastrium. The movements of the upper extremities were limited, but the lower limbs could be extended fully. The temperature was normal, although the patient complained of cold feet.

CASE 10.—(Lewin and Heller, 149). *DICKINSON* (*Obstet. Jour.,* 4, 1877). The patient was a boy, 3½ years old, in whom the edematous stage of the disease began acutely on the face and trunk. On the second day, the extremities were affected. The tongue became hard. It was difficult for him to open his mouth and eyelids. The forehead and scalp were hard. Sensation of the skin was normal. The skin was dry except for the soles and palms. There was recovery in seven months, although the face and scalp were still slightly indurated.

CASE 11.—(Lewin and Heller, 135). *MADER* (*Ber. d. kk. Rudolphstiftung uber 1877*). A girl, 17 years old, gave a history of cessation of menstruation, swelling of both ankles, knees and wrists, following exposure to cold air, eight months before. Six months previous to time observed, there was stiffness of the back and brown spots on the hands and face. The face, especially the lips, became hard. The skin of the rest of the body also became hard and thick. The neck was almost free. The skin over the joints of the lower limbs was most affected. All active and passive motions were constrained and painful. The attitude of the girl in bed was lifeless as a statue. The subcutaneous fat was absorbed. Eighteen days after admission (May 23, 1877) there were observed symptoms of pericarditis, and an enormous exudative pleurisy. July 26, the patient was bed ridden. September 18, there were chills, high temperature and diarrhea. October 1, vomiting began. October 8, daily vomiting of dark green masses, and much gastric distress. During her stay in the hospital, salicylates were found useless, and massage proved painful. Electricity and baths, however, were helpful. October 13, death occurred. The post-mortem examination disclosed universal scleroderma, thickened pleura and pericardium,

and fatty degeneration of the heart. There was an old tuberculous lesion of the left apex. The skin showed increased consistency and a thickening of the corium. In places, as on the face, there was slight atrophy of the subcutaneous connective tissue, but the fat was still present. The finger nails were thick and strong but not the nails of the toes.

CASE 12.—(Lewin and Heller, 290). *VENTURA (Gazz. med. ital.,* 1879). The affection occurred in a girl, 10 years old. The child was healthy until 1879 when pus was evacuated from a swelling on one of her fingers. There was no subsequent healing. She caught cold. There was a coryza, a cough and some fever. June 27, there was difficulty in talking and in opening the eyes. There was a feeling of tension in the head and over the breasts. Extensive induration of the skin was noted by the mother. The physician's examination disclosed a right-sided pleurisy, bronchopneumonia, and a diffuse scleroderma. The face, neck, arms and legs were especially affected. It was difficult for the child to speak or chew, or even to open her mouth. Walking was ungainly. The lung affection took a favorable course. There was a remarkable relapse of the induration of the upper lids, cheeks, neck, thorax, abdomen and lower extremities. The skin was like leather; that of the face was stony hard and glossy, and the scalp was sclerosed. The upper and lower arms were thin, without fat and with much evidence of atrophy. Sclerotic bands from the upper to the lower arm held the elbows half flexed. The genitals and feet were entirely free.

CASE 13.—(Lewin and Heller, 271). *SILBERMANN (Jahrb. f. Kinderh.,* 1880). The child, a girl, 5 years old, suffered with tonsillitis, pharyngitis, difficulty in swallowing, pains in her legs, and a scarlet eruption on her breasts, abdomen and arms of one day's duration. There was high fever and slight albuminuria. After the disappearance of these symptoms, there was enlargement of the lymph nodes behind both ears. Three days later, there was swelling of the eyelids. During the second week of her illness, there was slight hardening of the skin of the lower limbs. The tongue was harder than normal, and more difficult to move. The sensation of the skin of the forearms, chest, and upper extremities was lessened, and these parts also were deeply pigmented. Perspiration was normal. The temperature was subnormal. Recovery was complete in six weeks.

CASE 14.—(Lewin and Heller, 413). *FRIEDLANDER (Arch. f. Kinderh.,* 1888). A girl, 5 years old, was frightened by a runaway horse five months previously. Shortly afterward she was frightened by a sudden firearm salute in a church yard. The child's character changed. She complained of pain in the neck and a sense of constriction on opening the mouth. Her face was hard and immobile. Whistling was impossible. The neck and back muscles seemed to be fused with the skin into one hard mass, and there was difficulty in motion about the joints of the elbow, hand, knee and ankle. There were dark pigmented areas over the skin; abdominal breathing was difficult because of the great infiltration along the linea alba; the thighs and arms were hard; the uvula was rigid, and the gums were hard.

CASE 15.—(Lewin and Heller, 199). *WAUSSUROW (Klin. Samml. f. Dermat.,* Moskow, 1886). Following a cold, a young girl acquired universal scleroderma. The illness lasted six months. The patient had had a recto-vaginal fistula, also rectovesical and inguinal fistulae. The possible etiology was given as long continued absorption of pus.

CASE 16.—(Lewin and Heller, 318). *KROCHT (Moskauer venerol. Gesellsch.,* 1893). The patient was a boy, 12 years old. The entire skin except the fingers and the soles of the feet was hard. The skin of the thorax was especially hard. There were areas which were dark blue and much pigmented.

Acute diffuse scleroderma in a girl, aged 9 years. Note the absence of wrinkles or folds in the skin. The mouth and eyes are opened as wide as possible. Pressure with the finger does not pit the skin. The child was freckled under normal conditions.

ETIOLOGY

The investigation of the causes of diffuse scleroderma have not been definitely advanced since Osler[2] wrote long ago:

"We know really nothing of the essential causes, and the data are not yet at hand upon which a satisfactory theory can be based. The disease is variously regarded as a trophoneurosis dependent upon changes in the nervous system; a perversion of nutrition analogous to myxedema and due to disturbance of the thyroid function; a sclerosis following widespread endarteritis; a primary, slow hyperplasia of the collagenous intercellular substance of the corium—fibromatosis; or a primary affection of the lymph channels, central or peripheral. The first named view, the one most generally held, may well serve as a working hypothesis."

Foerster,[3] in a splendid article, reviews the part that the internal secretions play in scleroderma, among other skin diseases. He says:

"A review of the various observations, just recorded (cases of scleroderma with Graves' disease; with myxedema, and with ovarian changes) leads one to the conclusion that there are reasonable grounds for attributing an important part in the etiology of scleroderma to morphologic and functional changes in the internal secretory organs and especially in the thyroid gland. This newer conception would seek to displace the at present widely accepted view that scleroderma is an 'angio-trophoneurosis,' and it appears even now to have much evidence in its favor."

A great number of the cases follow colds, exposure to wet and draughts. Tonsillitis preceding many of the recorded cases, coupled with the fact that the neck is almost always the first part affected, leads one seriously to consider scleroderma diffusa as an affection spreading from tonsillar lymphatic tissue, through the lymphatics of the skin. In the case now recorded such was probably the mode of infection, but at the time the child came to the hospital there was no evidence of tonsillar disease.

Amenorrhea is mentioned in several instances as the causative preceding event, and in one case great fright was supposed to have caused the affection.

The consensus of opinion today, with regard to the etiology of scleroderma, is that the affection is at least closely related to disturbances of function, or "unbalance" of the secretion of one or more so-called ductless glands.

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2. Osler: JOUR. CUTAN. DIS., December, 1898.
3. Foerster: JOUR. CUTAN. DIS., January, 1916.

DIAGNOSIS

Diffuse scleroderma in children is readily diagnosed, since the main symptom is so evident. From extensive circumscribed scleroderma it can be diagnosed by the history of onset, the lesions occurring as single patches which have progressed and the presence of new patches; by the presence of normal unaffected skin, and by the duration, which is usually long. From sclerema neonatorum, diffuse scleroderma is distinguished by the age of the patient, the former affection being present in the new-born or recently born, usually not later than two weeks, and by its fatal outcome.

Diffuse scleroderma in children is differentiated from cretinism by the lack of concomitant signs and symptoms.

SUMMARY

The case reported is an unusual example of acute diffuse scleroderma, in a child, 9 years of age. The disease followed a tonsillitis. It appeared first on the back of the neck, and spread so that no part of her body was left free. The heart rate was accelerated, but there was no evidence of cardiac disease. The mentality of the child was not affected. Malfunction of none of the glands of internal secretion could be determined. The child, after five months, had recovered. There remained some hardness of the scalp and of the skin of the thighs. No atrophy was present. Thyroid extract had been given for several months, but discontinued because of its effect on the heart rate and the presence of a tremor. Oil rubs had been given actively.

Histologic study was not possible, as a biopsy was refused.

Thanks are extended to Dr. Longcope of the Presbyterian Hospital for permission to report the case, and for the photograph.

Clinical Reports

A CASE OF SYPHILITIC KERATODERMA*

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The case that I wish to report to you is one of syphilis as seen in one of its rarest manifestations, namely, syphilitic keratoderma.

History.—The patient, a salesman, aged 50, married eleven years, with no children, was referred to me March 13, 1917, by Dr. W. H. Groves of Burnhamthorpe. He was suffering from a severe attack of erysipelas of the face and scalp, which nearly proved fatal. In the course of routine examination I found the skin lesion which I am about to describe. Further questioning brought out the fact that about thirty years ago he was infected with the *Spirocheta pallida* and had the usual hard chancre, sore throat and other early signs of syphilis.

Two years after the time of infection a "pimple" appeared on the back of the left heel. This ruptured and discharged thick, black contents. Ever since then he has had trouble with his feet. Twelve years later, that is about fifteen years ago, the condition as I found it in March began. For about five years it was limited to one foot, but after that time it developed on the other foot in a similar manner.

When seen in March, 1917, both feet were very edematous, being too big to get into any boots that he could buy. He gives a history of an attack of acute nephritis twenty-five years ago, but at present the urinalysis shows neither albumin nor casts. The edema has been present about fifteen years. There is slight pitting on pressure, but not nearly as much as one would expect from the amount of swelling. The edema improves a little during the night.

Examination.—The soles of both feet were covered by a very thick skin of a dirty whitish color. It was extremely hard and rough, like shagreen leather. At the fold of the toes there were deep cracks, from which there exuded a little seropurulent discharge with a very foul odor. He stated that at times this discharge is so great that it soaks through his shoes. Here and there one could see cracks in the hardened epidermis a quarter of an inch deep, the tissue at the bottom of the crack being red, but not ulcerated. This condition extended over the sides and top of the feet and more or less up the legs, on the right side reaching about half way to the knees. On the sides and backs of

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* Reported before the Ontario Medical Association in Toronto, May 31, 1917.

Fig. 1.—Plantar surfaces of both feet covered with hard and warty skin resembling rough-grained leather.

Fig 2.—Warty excrescences, many of them as large as a 25 cent piece, were located on the heels and ankles.

the feet the hyperkeratosis was more of a verrucous nature, the warts being nearly half an inch thick, and varying in area from the size of a 5-cent piece to a quarter. When one tried to dislodge these excrescences, one found that they were very adherent and almost tore the surrounding skin instead of breaking off. Under them the skin was red and indurated.

Clinical Course.—The patient has had considerable pain in his feet for fifteen years. This was of a dull aching character most of the time, being worse before a change of weather and the first thing in the morning, and seemed to be "right in the bones." At night, in bed, his feet would be so burning hot that he could not sleep.

About six years ago, he also had the same hyperkeratosis on the palmar surfaces of his hands, extending to his wrists and the first

Fig. 3.—Showing the extreme verrucous nature of the hyperkeratosis over the heels and ankles.

two joints of his fingers. The skin at first seemed to thicken like a callus, then became hard, dry and rough, and cracked at the joints. From these cracks a discharge exuded similar to that from the feet. The hands were also somewhat swollen. This condition lasted for six to eight months, but now the skin is perfectly normal without even a scar left to show where the trouble had been.

Treatment.—He has had treatment almost continuously since he had his first symptom. This consisted mainly of mercury and iodids. If he persisted in careful treatment and was in good health generally, his skin condition would improve, but his feet have not been free from swelling or hyperkeratosis in fifteen years.

March 18, 1917, the Wassermann reaction was reported strongly positive. The photographs shown in Figures 1, 2 and 3 were taken April 28.

April 29 he received an intravenous injection of 0.6 gm. of diarsenol. He has had a similar dose about once a week since, in all thirteen doses. After the fourth dose his feet were much improved as shown in Figures 4 and 5. At the date of writing, the skin of his feet is perfectly normal, but the swelling has not completely disappeared.

Fig. 4.—Marked improvement in the condition of the soles of the feet after four weeks' treatment with diarsenol intravenously.

The skin of the sole is red, but appears healthy and is as soft and smooth as a baby's, there being no scar tissue whatever, showing that the condition was purely epithelial. There is no discharge or bad odor, and for the first time in fifteen years he is free from pain and burning sensation.

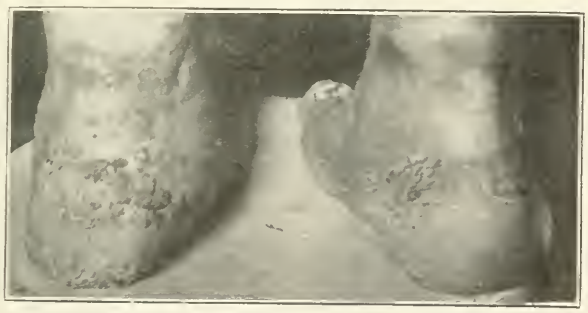

Fig. 5.—Under systematic treatment the skin has cleared up. The surface is reddened but otherwise is becoming smooth and normal. No scarring follows, since the condition involves only the superficial, epithelial layer of the epidermis.

REVIEW OF THE LITERATURE

In searching the literature for a description of this condition or reports of cases, I have been able to find only three references to it. Crocker, Hyde, Dearborn, Pusey, Macleod and Knowles make no men-

tion of it in their texts. Even Sir Jonathan Hutchinson, whose acumen as a clinical observer is unsurpassed, does not mention a similar type of lesion.

Stelwagon[1] casually refers to papillomatous and vegetating syphilides.

Sequeira[2] describes it as a rare type of tertiary syphilid and says, "it is found as a rule on one foot only, and in some cases it is associated with a pseudoelephantiasis of the limbs. The whole leg is swollen and does not pit deeply on pressure. The condition is believed to be due to lymphatic obstruction, but it is rare to find palpable enlargement of the glands." This description by Sequeira fits this case, except that the condition appeared on both feet and the hands. No palpable glands could be found.

Abraham[3] of the West London Hospital reported a case of a late squamous syphilid of the foot showing great hyperkeratosis of the sole superimposed on an infiltrated and hyperemic surface, while the natural lines of the skin were marked by deep fissures. His case improved at first under antisyphilitic treatment, but a fungating epithelioma developed near the heel and the limb had to be amputated.

The late Percy H. Ealer[4] of Philadelphia reported a case in 1915, in which there was a small verrucous patch on the heel which cleared up under treatment with mercury. In his report he says that "this syphilide being a late manifestation of the disease, is therefore asymmetrical. It is also indolent and chronic and may resemble an atypical epithelioma which is not an unusual termination." In the case described in this report the condition was symmetrical. It is well to bear in mind the possibility of the condition becoming malignant, especially in this case, as it has been present for so many years.

One point that I wish to emphasize about this rare lesion is that it does not extend any deeper through the skin than the epithelial layer. This is proved by the fact that it leaves no scar when healed, or even when the scales are removed by force.

I wish to express my thanks to Dr. W. B. Thistle for urging me to report this case, and to Drs. F. C. Harrison and E. J. Trow for their invaluable help in the preparation of this paper. I am also under obligation to Miss Bancroft of the Toronto General Hospital, Roentgen-Ray Department, who so efficiently made the photographs for me.

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TWO CASES OF GONORRHEAL KERATOSIS*

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CASE 1.—*Clinical History.*—The case about to be described is the third case of keratosis involving the feet which has occurred in many thousands of cases of gonorrhea treated at a venereal hospital.

The clinical appearances in each case have been different. In the first case the lesions were all discrete and comparatively few in number and presented the typically hard, shotty cones. The second case, which was published in the *British Journal of Dermatology,* April, 1917, was a general plantar keratosis.

This case—the third—was one of an old gonorrhea complicated with chronic prostatitis. He was readmitted to the hospital in November, 1916, with gonorrheal rheumatism. Both knees, the left ankle and the tarsometatarsal joints of the feet were affected. Iritis was present in both eyes, and the patient showed marked emaciation which is characteristic of these cases. He was very ill and ran a temperature of 101 to 102 F. The blood culture was negative.

Description of the Lesions.—Lesions were found on both feet and looked like flat pustules, varying in size from that of a split-pea to that of a 2-shilling piece. They were flat, almost circular and practically white in color, with a trace of inflammatory areola. They were situated on the plantar surfaces of almost all the toes and on the balls of the feet, and all were discrete (Fig. 1). There was no pronounced alteration of the skin over the heel or plantar arch of the foot. On the left foot, the dorsal surfaces of three of the toes presented an appearance which on first sight looked almost like chilblains. The skin was red, tender, and there was distinct swelling. The skin at points was just beginning to dry and become crusted. The whole foot was swollen, due to gonorrheal arthritis.

The largest lesion, about the size of a 2-shilling piece, was on the ball of the great toe. The superficial skin was broken and on reflecting the loose skin a fine layer of white, cheesy material was exposed. On removing this a raw red surface remained.

On the right foot very similar lesions were seen but they were fewer in number. The smallest lesions were about the size of a pinhead and looked like the commencement of staphylococcic pustules. The lesions were situated on the plantar surfaces of the toes and along the ball of the foot. A similar chilblain-like appearance was present on the great toe, little toe and third toe. The skin over the rest of the foot appeared quite normal.

Progress.—As the case progressed the typical hard, dome-shaped lesions with the limpet-shaped crusts developed, which were so striking in the other cases.

The lesions disappeared with desquamation of the skin, and the man returned to duty. The length of time that he was in the hospital was three and one-half months.

CASE 2.—This case showed the exceedingly rare condition of keratosis confined to the penis.

Clinical History.—The patient exposed himself to infection on June 3, 1917. June 21, he noticed a urethral discharge. This was his first attack of gonorrhea. He was treated privately, taking sandalwood oil capsules and syringing twice daily with permanganate of potash. July 10, his right knee became swollen.

* Received for publication October, 1917.

Fig. 1 (Case 1).—Lesions on the plantar surfaces of the toes and feet in a case of gonorrheal keratosis. The whole foot was swollen, the skin broken, and white cheesy detritus was exposed.

Fig. 2 (Case 2).—Gonorrheal keratosis and balanitis circinata. The lesions were covered with greenish colored, glutinous crusts which overlapped like a coat of mail.

Condition on Admission.—He was admitted to the hospital July 12—the twenty-first day of his illness. The patient's temperature was 100.2 F., and there was much swelling of the right knee joint and edema of the prepuce.

Progress.—Within four days the left knee joint became swollen, and a few days after both ankles became affected. The fever continued to range between 99 and 101 F. Twelve days after admission, the glans penis was noticed to be sore and crusted, but it was not until a week later that the crusted condition assumed a very striking appearance and the diagnosis "keratosis blennorrhagica with balanitis circinata" was clearly established.

The penis was swollen and painful; the prepuce had been retracted beyond the glans penis so that there was a considerable degree of paraphimosis. The appearances found at the time of diagnosis are shown in Figure 2. Over the swollen retracted prepuce and over the glans penis there was a very thick, dirty-green, glutinous crust, covering almost the whole of the glans and the inflamed paraphimosed prepuce. These crusts were like thick plates with sharply-defined, rounded edges, covering the parts almost like a coat of mail. Two or three small, early lesions were present on the posterior surface near the frenum, consisting of small circinate lesions of balanitis circinata, about the size of half of a split-pea, which were already showing a tendency to dry and become crusted.

About two weeks later the crusts were gently peeled off, leaving a red, fairly normal looking membrane. Recrusting of the glans penis started a second and a third time, but never again assumed the very striking appearances of the first condition. Owing to the general condition of the patient and the arthritis, no active local treatment could be carried out for some time.

The urethral smear showed a typical film of acute gonorrhea, and the prostate gland was acutely inflamed with an abscess in the right lobe. The patient's eyes were not affected.

At the time of writing this article the patient had greatly improved and was still under treatment.

Society Transactions

NEW YORK DERMATOLOGICAL SOCIETY

Regular Meeting, Oct. 23, 1917

JAMES C. JOHNSTON, M.D., *President*

GRANULOMA FUNGOIDES. Presented by DR. HEIMANN.

The patient had been presented before the Society in February, 1916, as a case of pityriasis rubra of the Hebra type. At that time the patient was covered with a general exfoliative dermatitis. The disease had started a year before with a small itching spot, which had spread rapidly. The patient had at times a temperature of 104-105 F., slept poorly and was generally in a run down condition when presented. At that time the consensus of opinion was in favor of the diagnosis of pityriasis rubra of Hebra. A little later he began to develop nodules in the skin; one of these was excised and showed an infiltration which was not typical of granuloma fungoides. Then he went to the Mount Sinai Hospital and was treated with the roentgen ray, and then to Vanderbilt Clinic, where also he was treated with the roentgen ray. He then wanted to go to Europe and was referred to Jadassohn, who considered the case one of mycosis fungoides.

On presentation the man's skin was normal, excepting that it was deeply pigmented.

LICHEN PLANUS. Presented by DR. HEIMANN.

The patient was a young man, under 20, who in May appeared for the treatment of a diffuse itching. On the right thigh he had a group of elevated spots forming small plaques, half an inch in diameter; on his belly were small brown spots, and there were also lesions on the penis and thigh. None of the usual treatments benefited him, and finally, considering the nature of the spots on the abdomen, it was suspected that it might be a case of lichen planus, while those on the thigh suggested lichen planus hypertrophicus. It was accordingly decided to try roentgen ray treatment to produce involution of the lesions, and this proved successful. From time to time the itching, which could not be explained, became latent, but the pigmentation on the thigh and abdomen persisted. The lesions of the penis also suggested lichen planus. The case seemed worth showing on account of the history and the conclusions reached.

ACNITIS (Tuberculid). Presented by DR. TRIMBLE.

The patient, a young woman, aged 16 years, was born in the United States. There was no family history bearing on the case. The eruption began about two years ago, appearing first on the face; then similar lesions developed on both arms. They consisted of necrotic papules and pustules, some of which had resulted in depressed scars. The scars on the arms were more typical than those on the face.

PECULIAR DEPIGMENTATION OF THE NECK. Presented by DR. TRIMBLE.

The patient was a young woman, aged 20, born in Russia, who presented a peculiar light brown pigmentation on the neck, reaching as far down as the shoulders. It was almost a counterpart of the well known pigmentary syphilid. There was, however, no history of syphilis, and the Wassermann reaction was negative.

DISCUSSION

DR. HEIMANN said that in his opinion there were two anatomic processes going on; on the one hand, pushing aside the pigment; on the other, atrophy. He thought that the patient might present that very peculiar form of scleroderma—white spot disease. The lesion seemed to be in the white areas.

DR. JOHNSTON agreed with the opinions expressed, but did not see any evidence of an inflammatory process. Dr. Heimann identified the condition more nearly, perhaps, when he likened it to disseminated morphea, or white spot disease. The basic lesion was probably a thrombosis of the superficial capillaries of the skin, an atrophy like that which took place in lupus erythematosus.

DR. TRIMBLE said he had seen the patient only once before, and had presented her because the condition bore such a strong resemblance to the pigmentary syphilid, although it was known not to be that. He was not inclined to think there was atrophy in the lesion. This crinkling that had been spoken of might be due to the twisting of the neck from one side to the other. The pigmentation of the neck was, in his opinion, the disease, not the white areas; the latter areas corresponded to the normal skin. He therefore considered it a hyperpigmentation rather than a leucoderma.

DISCOID ERYTHEMATOUS LUPUS. Presented by DR. TRIMBLE.

The patient was a negress, aged 35. The lesion, which was situated on the forehead and cheeks, was very dark colored, infiltrated, and had a distinctly raised border, which was at first somewhat festooned. The Wassermann reaction was ++++ when she first came to the clinic. She was treated for syphilis in the usual way, with salvarsan and mercury, without material effect on the skin lesion.

ICHTHYOSIS HYSTRIX. Presented by DR. MACKEE.

The patient was a girl, aged 7 years. The eruption began shortly after birth with a generalized erythema. After lasting for several months, this erythroderma gradually disappeared as the horny layer became thicker. Finally, there developed a universal ichthyosis. All the flexures were involved. The face, scalp, palms and soles were scaly. Elsewhere the ichthyosis was of the hystrix variety, the horny layer being black and papillomatous. Every summer there had been a remarkable exfoliation, the patient's skin becoming almost normal. The patient's mother stated that the child's hair and nails had always grown very rapidly. This case, the speaker said, would undoubtedly be regarded as an example of the dry type of erythroderma congenitale ichthyosiforme.

DISCUSSION

DR. SHERWELL agreed with the diagnosis, and then asked if the sebaceous glands were normal. The case somewhat resembled a seborrheic ichthyosis, which becomes better of itself in summer. The true ichthyoses have entire absence of the sebaceous glands. The child's skin was soft and pleasant to the touch, and it would seem to be not a true case of ichthyosis.

LUPUS ERYTHEMATOSUS WITH NODULAR LESIONS. Presented by DR. WISE FOR DR. FORDYCE.

S. G., woman, married, aged 27, applied at Dr. Fordyce's clinic Oct. 15, 1917. She gave a history of having had an attack of appendicitis five years ago, and the lesions of lupus erythematosus appeared shortly afterward. Besides the ordinary diffuse lesions of the face and forehead, the patient presented several tumorlike, discoid, raised, infiltrated and well circumscribed lesions on the arms and trunk, resembling the type of nodular lupus erythematosus as

described by Crocker. On the backs of the elbows and forearms were numerous scars of papulonecrotic tuberculid.

DISCUSSION

DR. MACKEE said he agreed with the diagnosis of papulonecrotic tuberculid of the forearms. The lesions of the face he thought the ordinary type of lupus erythematosus, while the lesions on the arms and chest he regarded as sarcoid. Dr. Wise mentioned Crocker's nodular lupus erythematosus. Almost every case of Crocker's nodular lupus erythematosus that had been presented in New York had turned out to be sarcoid.

DR. TRIMBLE said that he had recently had a case of erythematosus lupus in association with sarcoid. The sarcoid lesions were investigated histologically and proven, but no biopsy was made of the lupus erythematosus on the face, since the case was regarded as one of sarcoid. In his patient the sarcoid lesions were the most extensive, and the lupus erythematosus was confined to the face. A similar condition might exist in the case under discussion, though Dr. MacKee had said that one of the lesions on the woman's right arm had broken down. If that were true, it would eliminate sarcoid. Should these lesions necrotize they would be, in the speaker's opinion, analogous to Bazin's disease.

DR. MACKEE, replying to Dr. Trimble, said that the lesion on the arm had involuted without breaking down and had left a deep atrophy. One could see the atrophy, and on palpation the finger entered a deep depression. The deep atrophy was rather characteristic of sarcoid.

DR. HEIMANN said he was inclined to agree with the view expressed by Dr. MacKee, that there were three types present, and referred to the case shown by himself and asked, Why was this not Bazin's disease, too?

DR. LANE agreed with the diagnosis. The chief interest in this case was that in the same patient there were different reactions to what was evidently the same cause.

DR. JOHNSTON said that it made no difference to the rest of the medical world whether or not the lesions were differentiated. Every one knew that they were all the same thing, just as much as the squamous papillary syphilid was the same as gumma. These distinctions were of value only to the dermatologist.

ATROPHODERMA CIRCUMSCRIPTUM. Presented by DR. WISE FOR DR. FORDYCE.

A. W., woman, aged 29, married, apparently in good health, applied at Dr. Fordyce's clinic Oct. 5, 1917. Her affection was of eight years' duration. On the upper portion of the back, sides of the neck, upper eyelids and on the shoulders were a number of isolated and confluent lesions of various types. The right upper eyelid presented an oval patch of atrophic skin with evidences of anetodermia. Similar much smaller lesions were present on the sides of the neck. On the upper part of the neck was a large, roughly triangular patch of raised, slightly infiltrated skin, presenting a reddish to violaceous tint. Its surface was smooth, free of scales, somewhat indurated and resembling an area of persistent urticaria diffusa. In some areas there was distinct depigmentation. The follicular orifices were well marked in most of the lesions. Opposite the dorsal vertebrae were two pea sized, soft tumors, simulating von Recklinghausen's disease. None of the lesions had changed in appearance in the past three or four years.

DISCUSSION

DR. HEIMANN stated that there was little to be said about the case. Three conditions suggested themselves: Macular atrophy, of Jadassohn, multiple benign tumorlike growths of the skin, of Schweninger-Buzzi, and sarcoid. He did not think it was sarcoid, but that the diagnosis lay between the first two mentioned. Recently many authorities ceased to differentiate the two.

DR. MACKEE agreed with Dr. Heimann. He thought that the lesions represented the early edematous and erythematous stage of macular atrophy. The speaker recalled a case presented by Dr. Gottheil several years ago where similar lesions showed under the microscope nothing but a marked edema of the connective tissue.

DR. JOHNSTON asked whether in the case of a tumor with so much consistency as this the skin which has been stretched for months or years would not show an atrophy which would have nothing to do with the original process as such.

FOLLICULAR LICHEN PLANUS. Presented by DR. HEIMANN FOR DR. WHITEHOUSE.

The patient was a woman, aged 45 years, who came from Dr. Whitehouse's service at the Post-Graduate Hospital. The patient had been ill for three months and presented a mixed type, follicular and annular, lichen planus scattered over the limbs and trunk.

LUPUS ERYTHEMATOSUS DIFFUSUS. Presented by DR. WISE FOR DR. FORDYCE.

J. W., man, aged 51, married, native of the United States, applied at Dr. Fordyce's clinic Oct. 22, 1917. His disease was of seven years' duration. He was afflicted with pulmonary tuberculosis. He presented a diffuse and widespread erythematosus and scaly eruption affecting the face, chest, back, arms and the backs of the hands. The lesions on the backs of the fingers resembled ordinary perniones.

CASE FOR DIAGNOSIS (ENDOTHELIOMA). Presented by DR. MACKEE FOR DR. FORDYCE.

The patient was a man, aged 29, from Dr. Wise's service at Mt. Sinai Hospital. The duration of the eruption was eight years. The lesions were located on the chest, neck and upper back. They consisted of yellowish to yellowish-brown, pinhead to split pea sized papules of a slightly flabby consistence. These lesions were scattered, for the most part, over the chest. They were both discrete and confluent. Over the sternum were several large comedones, a few sebaceous cysts and fibromas. Clinically, the diagnosis rested between syringoma and fibroma. The lesions did not appear sufficiently firm for syringoma, nor were they dark enough. At the same time they seemed to be too firm and too dark for fibroma.

The histology showed a dense infiltration of large round cells with granular cytoplasm. For the most part the nucleus was centrally placed, but when eccentric the appearance was that of a plasma cell. The cells, also, were suggestive of nevus cells. In the dense mass of infiltration the cells could be seen in columns, pavementlike, as though ducts were being formed. In the sections from the earlier lesions these cells were seen to be derived from the blood vessels or from the perivascular lymph spaces, and for this reason the new growth was thought to be an endothelioma.

DISCUSSION

DR. JOHNSTON pronounced the lesions as endothelioma.

DR. HEIMANN said that a point which aided Dr. Johnston's attitude was the beginning of tumor growths in the perivascular lymph spaces.

DR. JOHNSTON replied that if the origin of the cell can be traced to its parent in the beginning of the tumor, that solves the question of diagnosis and of varying physical features. The histological picture was that of endothelioma.

SUBCUTANEOUS GUMMA. Presented by DR. HEIMANN.

This patient had been presented before the Clinical Section of the American Medical Association with the diagnosis of subcutaneous gummas of an unusual

type. At that time he had twenty-two gummas on the right hand and eleven on the left. The Wassermann reaction was +++ and the microscopical examination was fairly typical. The history given was that these lesions had been present for two years before he was shown, but that they had increased in number. There was also a history of a primary lesion twenty years ago.

The speaker said that the only reason he had happened to think of gumma was that he had seen a similar case some years ago, the gummas in that instance extending over the fingers. The man had had six or seven salvarsan injections during May and June and three or four since. There were now eight lesions on the right hand and none on the left. There were also two very minute nodules under the skin at the points of the elbows. Several of the lesions on the hand might well be only calluses, since the man was a printer and was liable to develop such calluses. At present the Wassermann reaction was very weak. (Dr. Heimann showed pictures of the condition as it appeared when first seen.)

NEW YORK ACADEMY OF MEDICINE

Section on Dermatology

Regular Meeting, May 1, 1917

GEORGE M. MACKEE, M.D., *Chairman*

PELLAGRA. Presented by DR. WISE.

C. F. M., man, aged 62, was a native of the United States and had been a resident of New York City all of his life. He presented himself at Dr. Fordyce's clinic with a rather well developed erythema of the backs of the hands, the frontal portion of the face and the sides of the neck. The redness of the skin first made its appearance about two weeks before. The backs of the hands were purplish-red, the skin was smooth and covered by a layer of fine, adherent scales. The erythema extended up to the wrist joints. The hands were tender, but itching was absent. The nose and the adjacent skin was reddish-brown, scaly and somewhat rough in appearance. On the sides of the neck were a few circumscribed, erythematous, scaly patches. The patient had been under the care of a physician for the past ten months, for the treatment of "stomach trouble." The patient stated that he had been losing weight steadily during the past year. There were no intestinal or mental symptoms. The tongue, however, was smooth, red and glazed.

DISCUSSION

DR. HEIMANN agreed with the diagnosis because of the marginated, erythematous lesions on the hands and the eruption on the face. The history, the speaker thought, was a little unusual.

DR. CHARGIN agreed with the diagnosis and said that he recalled a similar case. It was usual for the eruption to be worse in summer; in Dr. Wise's case the eruption, however, began late in winter. The speaker also called attention to the fact that there was some atrophy on the backs of the man's hands.

DR. SATENSTEIN (by invitation) said that he had seen cases in the City Hospital which had been diagnosed as pellagra but which the neurologists said were due to an alcoholic neuritis.

DR. MACKEE said that there was hardly any question about the diagnosis. The plaque on the back of each hand, possessing a bronze-red color and ending abruptly at the wrists, was typical. There was also a collarette consisting of thickened horny layer and erythema on the neck. The face showed the horny spines so commonly seen in pellagra. The gastro-intestinal symptoms, while not marked, were definite. He had been constipated and had no appetite and

had been more or less nauseated over a period of a year or more and during this time he had lost 50 pounds in weight. The patient was very despondent, even melancholic. The man was not an alcoholic. The most interesting point about the case was that the disease, in this instance, was indigenous to New York. The man was born and had always lived in New York City. Three years ago he was in Hartford, Conn., for nine weeks. Eighteen years ago he was in the South for a few months. The speaker said that there were only three or four cases reported in the literature in which the disease developed in New York State. It was doubtful if these patients did not contract the disease elsewhere. Several cases of pellagra had been seen in the various institutions of New York City and state, which had not been recorded. In all probability the disease was much more common in New York than had been supposed, but the cases had not been recognized.

DR. POLLITZER agreed with the diagnosis and called attention to the glossitis which this patient presented and which was frequently seen in this disease. The speaker said that there was no doubt but that cases developed in New York City and that they were much more common than was supposed. He had called the attention of the Health Department to this fact several years ago. He recalled a case that he had seen at the Post-Graduate Medical School; a young woman who lived in New York but had traveled occasionally and had been in Virginia just before the disease developed, had a marked inflammation of the buccal mucosa together with severe gastro-enteric symptoms. The speaker said that Dr. Wise's case was undoubtedly one of pellagra in a native of New York who had not resided elsewhere.

LUPUS ERYTHEMATOSUS. Presented by DR. ROTHWELL.

The patient was a woman, aged 45, married, housewife, who presented about the nose and mouth, extending down to the chin, a number of dark-reddish, slightly infiltrated, only slightly scaly lesions, of about pea to bean-size; the borders of the individual lesions were quite distinct and there was but little elevation above the level of the uninvolved skin. While the general area involved was that about the mouth, there was also involvement of the vermilion border of the lips and the mucous membrane on the inside of the cheeks, and the exterior of the right ala nasi.

The portion of the ala nasi involved showed distinct and adherent scales; the vermilion border showed only a very thin scaliness with appearance of thinning of the border itself; the inside of the cheeks showed some reddened area with thinning, and some whitened areas.

The affection began eight years previously within the mouth and was considered by the patient to be due to contact with carious teeth; about one year previous to presentation it appeared on the right cheek, spread over both lips and chin, and then gradually disappeared to some extent.

The Wassermann test was negative.

LESION ON THE TONGUE, FOR DIAGNOSIS. Presented by DR. HEIMANN.

C. T., man, aged 38, married, was from Dr. Fordyce's clinic. His wife had had two miscarriages; one child was living and apparently healthy. He denied infection with syphilis. On the sides and dorsal surface of the tongue were several grayish-white, irregularly oval, somewhat raised, sharply outlined patches, said to have been present since the past year. They would sometimes diminish in size, but had never entirely disappeared. Eating sharp foods and ingestion of hot liquids provoked considerable pain. There were no clinical evidences of syphilis. The Wassermann test had not yet been reported.*

*The Wassermann test was + + + +.

DISCUSSION

DR. CHARGIN thought the case was one of syphilis. He called attention to the fact that the lesions were circinate, the rear patch being made up of three distinct confluent papules.

DR. POLLITZER said that he was not prepared to make a diagnosis. The fact that the lesions had existed a year without distinctly progressing was against syphilis. If, however, it were syphilis it would have to be a gumma, as a mucous patch would not last a year and it would not be covered with a false membrane as in this case. He would think seriously of a trauma with a possible infection with Vincent's spirillum.

DR. HEIMANN said the fact that the lesion was stationary would indicate that it was a low-grade injury. The speaker said he would investigate and see if he could demonstrate Vincent's spirillum. He would also have a Wassermann test made and would endeavor to make a biopsy. He thought the diagnosis rested between gumma and some ordinary inflammatory ulcer.

LYMPHANGIECTASIS. Presented by DR. ROTHWELL.

The patient was a man, aged 55, married, Russian, tailor, who presented a general enlargement of the left leg (from knee to toes) with many small, compressible, thick and thin walled, pearly and reddish, vesicular dilatations, the last varying in size from a large pinhead to a pea. The general enlargement of the leg reached possibly two or two and a half times the size of the right leg; the swelling could be made to pit on pressure, but there seemed to be a general hyperplasia of the involved tissues. On the lower, front portion of the leg the surface presented a warty appearance, probably the sequel of the drying up of preceding vesicles.

There was a history of thirteen years' duration and no history of any traumatism to account for the occurrence. The patient complained that it was difficult to walk about and to use his foot on sewing machines.

DISCUSSION

DR. LAPOWSKI said that he was in doubt about the diagnosis. He had had the patient under observation several years ago at which time there were annular patches composed of tuberculid-like lesions. The Wassermann reaction was negative. He gave the patient calomel injections and the lesions disappeared, leaving scars. New lesions developed later. He had considered the case to be one of tuberculid and had never seen a papule or vesicle from which lymph could be obtained.

CASE FOR DIAGNOSIS. Presented by DR. LAPOWSKI.

B. P., boy, aged about 8 years. The eruption, which started one year ago, consisted of an erythematous patch which extended from the buttocks to the lower third of the thighs. The patches on the thighs were sharply defined, slightly infiltrated and if left without treatment would, in a few days, be covered with very thin, hardly noticeable, dark-brown scales, accompanied with some fissuring. The patches were dry but not itchy. Three months ago the eruption appeared on the face, arms and extremities but soon vanished, leaving only the eruption on the thighs.

DISCUSSION

DR. SATENSTEIN (by invitation) said that the peculiar situation of the lesion suggested the possibility of a local irritation produced by sitting on a lavatory seat which perhaps had been cleansed by some irritating chemical.

DR. HEIMANN said that the case was one apparently of dermatitis with thickening of the skin and the location and the sharp limitation suggested a local etiologic factor. The speaker thought that Dr. Satenstein's suggestion was a very good one.

DR. POLLITZER thought that the location would rule out Dr. Satenstein's suggestion because the lesions extended well on the sacral region. The slight infiltration, erythema and scaliness suggested parapsoriasis or parakeratosis. The speaker did not care to commit himself to a diagnosis without further study of the case.

DR. HEIMANN did not agree with Dr. Pollitzer in regard to the location of the lesion ruling out Dr. Satenstein's suggestion. He called attention to the fact that the boy was very small and that contact with the lavatory seat might extend well up on the sacrum and to the thighs.

DR. LAPOWSKI said that he could rule out the local cause which had been suggested, because for four weeks the boy was dressed with a mild salve and bandages from the knee to the waist. The dressings were removed in the dispensary.

TOXIC ERYTHEMA WITH ANNULAR AND BULLOUS LESIONS. Presented by DR. LAPOWSKI.

The patient, Mrs. S. R., aged 49, had been under the speaker's observation since 1908. In that year, in the ninth month of her sixth pregnancy, the patient complained of pruritus of the abdomen. There was no eruption until after confinement, when serpiginous and annular erythematous patches, containing bullae and vesicles, occurred on the thighs and back. This eruption disappeared in two months. A year later, during another pregnancy, there was another eruption which began with pruritic, urticarial wheals. Later the eruption became configurate and involved the buttocks, crura and the flexor surfaces of the forearms and thighs. Vesicles and bullae were also present. The patient had chills and fever and nausea. The mucous membranes were not affected. The eruption disappeared only to reappear in a month, without premonitory symptoms and accompanied by vomiting spells. The patient at this time was pregnant and three weeks before confinement there was not a lesion on her body, but directly after confinement there was a fresh outbreak. In 1911, the patient received a burn on the right thigh which left a hypertrophic scar. In 1914, the patient had an attack of herpes of the right cheek and impetiginous lesions appeared at the mucodermal junction of the upper and lower lip. These lesions disappeared in one week. In the same year, independent of gestation, the erythemato-urticarial, vesiculo-bullous eruption reappeared. This was preceded by chills and fever. In this attack the buccal mucosa was involved. From 1914 up to the time of presentation there were one or two recurrences each year, always of the same type and location. When the patient was presented before the Section she was suffering from an acute outbreak of this eruption.

DISCUSSION

DR. SATENSTEIN (by invitation) suggested that the patient's teeth be examined as the eruption might be due to and kept up by a focal infection.

DR. LAPOWSKI did not think the teeth had anything to do with the condition as these eruptions appeared in cases when there was no dental disturbance and in other cases the eruption reappeared after faulty mouth conditions had been corrected.

TOXIC ERYTHEMA WITH URTICARIA IN A SYPHILITIC. Presented by DR. LAPOWSKI.

The patient, Mr. P., aged 25, had a penile chancre five years ago, followed by clinical manifestations of secondary syphilis. He received many injections of mercury and one intravenous injection of salvarsan. The eruption for which the patient was presented developed fifteen months ago. When presented before the Section, the eruption was limited to the neck, shoulders, trunk and the upper extremities. The lesions consisted of erythematous patches, urticarial wheals and nodular lesions simulating the papulo-necrotic tuberculid. In many places

the papular elements were arranged in circles and semicircles. The von Pirquet reaction was negative.

CUTIS MARMORATA. Presented by DR. LAPOWSKI.

The patient, L. D., was a boy, aged 15 years. He was a syphilitic and had been treated by inunctions and salvarsan injections. It was impossible to ascertain the date of the syphilitic infection or the beginning of the cutis marmorata. The condition was generalized. Almost the entire body was covered with purplish, annular macules which disappeared on pressure. The eruption was permanent, that is, it did not disappear and recur.

DISCUSSION

DR. HEIMANN said that the condition was certainly very interesting and perhaps unique. There had been a great deal of study and discussion relative to these vascular changes, which, however, had led to no definite conclusions. In this particular instance the vascular dilatation was permanent and it was difficult to see how this could happen without anatomic changes in the capillaries, especially the deeper veins. Stokes and others had described permanent capillary dilatation in the nature of telangiectasia but this case had nothing in common with those described by Stokes. The speaker was not willing to hazard an opinion until he had seen and studied more cases.

DR. POLLITZER called attention to the cutaneous circulatory distribution. The distribution of the capillaries in the skin was arranged in the shape of cones with their bases at the surface and their apexes deeper in the skin. These circular bases received a direct blood supply while the peripheries of the circles and the triangular spaces between adjacent circles were supplied by collateral vessels. If, therefore, the disturbance was in the area of direct circulation, the lesions would be circular; if the collateral circulation were disturbed the effect would be manifested in the collateral network on the surface. The speaker knew of no process that would produce a permanent cutis marmorata. Apparently there must be some change in the walls of the vessels and it was possible that syphilis was the etiologic factor.

DR. LAPOWSKI said that Ehrman and Adamson described cases similar to this one and Ehrman mentioned syphilis as a possible cause. The speaker said that it was to be regretted that in his case it was impossible to tell whether the eruption had appeared before or after the syphilitic infection. The speaker doubted if syphilis was the cause of the eruption in this case, as the lesions were too symmetrical, and were not influenced at all by treatment, while the papular lesions at the anus improved greatly. One calomel injection had been given without any improvement of the cutis marmorata. (The patient never returned.)

DERMATITIS EXFOLIATIVA. Presented by DR. LAPOWSKI.

The patient, R. I., was a man, aged 62. The eruption for which the patient was presented developed four months ago, on the left side of the cheek, as a small, scaling patch. Two weeks later, the entire face became swollen and scaling. The eruption appeared on the hands and then gradually spread over the entire body. The only past history that could be obtained was one of chills and fever, over a period of five years. When presented before the Section, the skin of the entire body was red and infiltrated and covered with easily detachable scales. The physical examination was normal as also was the urine.

DISCUSSION

DR. POLLITZER suggested the possibility of leukemia and requested that a blood count be made. He also suggested that a von Pirquet test be made, because tuberculosis might be the basic cause.

DR. HEIMANN recalled a case, the father of a colleague, who had a similar but more pronounced condition suggesting pityriasis rubra (Hebra). Treatment was unsuccessful for a long time. Finally a dentist extracted his teeth, which were all diseased, and shortly after the eruption disappeared and had never returned. The patient had had general adenopathies and the speaker considered, at the time, that among other possibilities there might have been a disturbance of one or more of the ductless glands.

DR. LAPOWSKI said that he had never seen or heard of a case in which the cause was definitely established. Such cases should be taken into the hospital and studied.

ARSENICAL PIGMENTATION. Presented by DR. WISE.

F. F., man, aged 39, a widower, was from Dr. Fordyce's clinic. He was a native of the United States and had spent several years in the tropics, where he had contracted enteric fever, for which he had been advised to take arsenic. He was also subject to epileptic attacks and had been taking potassium bromid, in conjunction with the arsenic. With varying intervals, he had been under arsenical medication during the past seven years. Syphilis was denied and the Wassermann reaction was negative. With the exception of the face, hands and feet, the skin of the entire body, but more especially the chest, back and abdomen, presented a dark-brown, mottled and reticulated pigmentary deposit. The skin was smooth and free of scales. There was a slight hyperkeratosis of the palms and soles.

DERMATITIS HERPETIFORMIS. Presented by DR. WISE.

E. R., man, aged 26, married, was a native of this country and applied at Dr. Fordyce's clinic for the relief of an intensely pruritic dermatosis which began six years ago, on the buttocks and elbows, as small papules and vesicles. He presented areas of grouped papules and broken down vesicles, together with large, well-defined patches of deeply pigmented skin, on the abdomen, buttocks, back and extremities. Over the buttocks, the grouping of the lesions and the degree of pigmentation were most pronounced. He had been subjected to many forms of treatment, apparently without avail.

DISCUSSION

DR. LAPOWSKI said that the patient had had the disease for six years and yet the trunk was entirely free from lesions which, he thought, was a very rare condition in dermatitis herpetiformis. The speaker called attention to the fact that there were annular eczematous lesions and he would suggest the diagnosis of parasitic eczema.

DR. HEIMANN said that he could see no grounds for the diagnosis of eczema marginatum. The case impressed him as being one of Duhring's disease and the fact that the trunk was free of lesions was no argument against such a diagnosis as such instances were rather common. The speaker called attention to the fact that eczema marginatum usually occurred in the groins and axillae and started as red, vesicular, circinate lesions which gradually became fused and festooned.

DR. POLLITZER agreed with the diagnosis of Duhring's disease and said that the fact that there were no lesions on the trunk was of little importance.

DR. LAPOWSKI insisted that this case was the textbook type of eczema marginatum of an aggravated form. The lesions consisted of circinate patches of vesicles and papules which spread and were very itchy.

DR. HEIMANN said that he believed that Dr. Lapowski was thinking of parasitic eczema and not eczema marginatum. Eczema parasiticum answered the description given by Dr. Lapowski but it did not answer the description of Dr. Wise's patient.

DR. MACKEE said that from Dr. Lapowski's remarks he imagined that Dr. Lapowski did not mean eczema marginatum but eczematized ringworm, resembling the cases shown by Dr. Ormsby at the last meeting of the American Dermatological Association in Detroit. An article on the subject was written by Ormsby and Mitchell and was a very excellent one. The lesions consisted of eczemalike patches on the backs of the hands and arms and also on the, feet, and occasionally on other parts of the body. The margins were not sharp. The skin was thickened, scaly, and there were vesicles, papules and sometimes exudation. Sometimes the patches were solid and sometimes circinate. They varied in size but usually ranged between a dime and a quarter in diameter. There was more or less itching. In other words, one would hesitate in making a diagnosis of eczema but in all these cases Ormsby and Mitchell were able to obtain pure growths of the ringworm spores. In Dr. Wise's patient there was a history of recurrent attacks of grouped lesions. In other words, over a period of several years there were distinct remissions and exacerbations and the disease had occurred on the trunk. The speaker thoroughly agreed with the diagnosis of Duhring's disease.

DR. WISE said that the appearance of the lesions, the course of the disease, the subjective symptoms, etc., were in his opinion, those of dermatitis herpetiformis.

CHICAGO DERMATOLOGICAL SOCIETY

Regular Meetings, March 20, April 17, and May 15, 1917

WILLIAM ALLEN PUSEY, M.D., *President*

RECURRENT INFECTION OF UPPER LIP—BEGINNING "SOLID EDEMA." Presented by DR. PUSEY.

The patient was a man, aged 37 who had a swollen upper lip. Three days ago there had been an acute swelling with redness of the upper lip. Inside the nose there was an abrasion on the septum.

DISCUSSION

DR. FOERSTER thought it was a folliculitis.

DR. ORMSBY thought that the disorder had begun through infection in the nasal mucous membrane, the lip change being secondary to this. He would connect this with the group of cases reported in the German Archives in 1912 by Dr. Pusey, under the title, "Solid Edema of the Face," the first case having been recorded by Hutchinson, in 1883. He thought it might be an early case of that kind, and that repeated attacks of inflammatory reaction would eventually produce the Hutchinson type of solid edema.

DR. EISENSTAEDT asked if there was no marked interference with the drainage of the lymph occasioned by anatomic or inflammatory lesions.

DR. PUSEY agreed with Dr. Ormsby that the case was a beginning elephantiasis of the upper lip from recurrent attacks of cellulitis. There was an excoriation of the septum which furnished the probable atrium for the infections. There was no evidence of mechanical obstruction aside from that due to recurrent lymphangitis.

MULTIPLE BENIGN CYSTIC EPITHELIOMA, SHOWN AS A PROBABLE ADENOMA SEBACEUM. Presented by DR. ORMSBY.

The patient was a young woman, aged 26, who had had the disorder fifteen years. The lesions had slowly developed since their initiation, and none had disappeared; all that had ever occurred were still present. They consisted of small papules and nodules, ranging in size from that of a pinhead to a small

pea or larger, they were colorless, some being semitranslucent. They were grouped on the upper lip, on either side of the nose, and on the temples. Isolated lesions were scattered about the forehead and cheeks. Some telangiectasia was present over certain nodules, and there was one pigmented nevoid lesion in the eyebrow. There were no subjective symptoms. At the time of presentation, a radiodermatitis following radium treatment was present on the upper lip.

DISCUSSION

DR. WILE said the case impressed him at first glance as possibly one of epithelioma adenoides cysticum. He considered cases of this description difficult of diagnosis without microscopic findings, but he thought it belonged to that group of diseases.

DR. EISENSTAEDT agreed with Dr. Wile, but would leave out the expression "epithelioma." He thought it belonged to the class described as adenoma sebaceum.

DR. FOERSTER thought it was suggestive of adenoma sebaceum, but that the semiglobular character and the color were against this diagnosis.

DR. PUSEY stated the appearance of the case as a whole suggested to him that it was a multiple benign cystic epithelioma, rather than an adenoma sebaceum.

DR. STILLIANS had not thought of adenoma sebaceum on account of the lack of dilated blood vessels.

DR. ORMSBY said there were several dilated blood vessels present, and he believed it was an adenoma sebaceum because it began at an earlier age than was common for multiple benign cystic epithelioma, and, furthermore, no other members of the family were similarly affected. The grouping of the lesions about the angle of the nose was characteristic of adenoma sebaceum.

From the clinical standpoint in this case, he thought a positive distinction could not be made between the two disorders, and that the decision must rest on the microscopic findings, which he hoped to be able to obtain, but he believed that adenoma sebaceum was the more probable.*

PARAPSORIASIS. Presented by DR. ZEISLER.

The patient was a woman, aged 30, who had a generalized eruption of fourteen years' duration. It began on the palms and soles and subsequently spread over the entire body. With the exception of one remission of two years she had had the eruption constantly, with exacerbation in the spring and fall. The condition had been diagnosed by various competent observers as psoriasis and dermatitis exfoliativa. There was a generalized scaly erythrodermia with confluent patches on the face, neck and trunk and isolated lesions on the extremities, with considerable fine desquamation. The general health was not at all involved and the blood count normal. The patient had at first improved under the administration of thyroid extract and roentgen rays, but had suffered an acute exacerbation after four weeks. She was then given six autoserum injections and a 1 per cent. chrysarobin salve and there had been some improvement under this treatment. She was presented as an instance of a persistent, scaly erythrodermia, belonging to the groups of parapsoriasis cases.

DISCUSSION

DR. WILE did not think one could say definitely at this time just what the eruption was. He thought there was some justification for believing it was a psoriasis which had become generalized. Secondarily, the case reminded him in one or two features of a stage in the course of pityriasis rubra of Hebra which had been modified by treatment. In favor of this there were distinct

* Note.—April 17; biopsy proved the growth to be a multiple benign cystic epithelioma.

areas of clear skin and distinct symmetry. He thought the extensive confluence of the eruption, amounting almost to an exfoliative dermatitis, spoke against the case as being one of parapsoriasis.

DR. EISENSTAEDT thought it had been a psoriasis to start with but that it had progressed to some other condition, possibly belonging to the dermatitis exfoliativa group.

DR. HURLBURT thought the case had been modified by treatment until it did not belong to any special type.

DRS. FOERSTER and ORMSBY agreed with Dr. Wile.

DR. PUSEY was not able to see evidence of psoriasis in the case and thought the process was too extensive to be representative of parapsoriasis. The patient had a general exfoliative dermatitis with a good deal of scaling. The skin was leathery and the lower lids showed ectropion, which indicated that there was a chronic inflammatory process that was drawing the lids down. This ectropion suggested Hebra's pityriasis rubra, and the other features of the case seemed to him to fall in more probably with that diagnosis than any other.

DR. ZEISLER said that when the patient was first seen there was not the diffuse redness present, and that he believed it had occurred as the result of the treatment.

PEMPHIGUS. Presented by DR. SHAFFNER.

The patient was a little girl, aged 8½ years. The condition had been present for about one and one-half years. The speaker had seen her a year ago and not again until a few days before she was presented. The mother claimed that the condition followed a vaccination done three months prior to the eruption. When first seen there were lesions in the mouth but there had been none since that time. There was no itching. There had been no improvement in the condition since the time of the first examination.

DISCUSSION

DR. EISENSTAEDT said the case belonged to the pemphigus group, possibly being an atypical case of dermatitis herpetiformis. He thought the large bullae all arose from an inflammatory base and there had been periods when the itching had been rather marked, and then remissions of the itching. He thought the case did not present the complete remissions which were characteristic of dermatitis herpetiformis.

DR. ORMSBY thought it was a case of bullous dermatitis but that it might belong to the pemphigus group.

DR. PUSEY thought the case was a border line case between pemphigus and dermatitis herpetiformis. He thought that vaccination had to be considered an exciting cause of some of these systemic cases of bullous eruption.

DR. FOERSTER said that he had seen an extensive erythema iris develop within forty-eight hours following vaccination, which was unquestionably due to the vaccination.

DR. SHAFFNER thought it was not a dermatitis herpetiformis, and as there had been a three months' interval between the vaccination and the eruption, he did not believe that was the cause of the trouble.

GRANULOMA PYOGENICUM OF THE SCALP. Presented by DR. STILLIANS.

The patient was a woman, aged 35, who had noticed a tumor on her scalp about two months previously. She did not know how it originated and it had caused no subjective symptoms but interfered with combing her hair. The tumor was on the right parietal region and was about 0.7 cm. in diameter, flat and pedunculated, covered by dark red, thin skin. Below the right mastoid was a mass of swollen, tender glands, about hazelnut size, not very hard.

DISCUSSION

DR. SHAFFNER considered it a low grade infection such as he had seen a number of times in women who irritated the scalp in combing the hair.

SEGMENTAL NEVI. Presented by DR. E. P. ZEISLER.

The patient was a man, aged 24, and was presented as a dermatologic curiosity. The condition had been present since birth, and as far as he knew there had been no special change in the last few years. The lesions consisted of wartlike nevi distributed along the course of the cutaneous nerves in a segmental fashion, with the peculiarity that the nevoid masses could be easily detached, leaving a reddened area underneath.

DISCUSSION

DR. ORMSBY considered the case extraordinary, on account of the facility with which the lesions could be removed. In many such cases, the lesions were very adherent, but these were soft, granular and sebaceous, and only lightly attached to the skin with a nevus-like arrangement.

CASE FOR DIAGNOSIS. Presented by DR. MACKEY.

The patient was a child, aged 10 years. Eight months ago she developed a patch on the left elbow and later one on the leg. There was mild itching. New areas had rapidly formed, until at the time of presentation there were symmetrical lesions with zoniform arrangement on the trunk, and thickened, scaling patches on the forearms, about the nucha and about the ears. There had been no treatment.

DISCUSSION

DR. WILE said the lesions behind the ears and those on the ears certainly could not have been associated with parapsoriasis; they were typical seborrheic areas and yet the lesions on the body were typical of the Brocq type of parapsoriasis. He thought both conditions were present.

DR. ORMSBY thought it was interesting to see such a young patient with a low-grade inflammatory process with all the appearance of a parapsoriasis of the plaque type. The lesions had been present for a long time and there had been no change. Those behind the ear were of the ordinary type seen in dermatitis seborrheica, and it was difficult to connect these with the plaques on the trunk. He believed the case represented a parapsoriasis of the plaque type.

SYPHILIS RESEMBLING LUPUS ERYTHEMATOSUS. Presented by DR. MCEWEN.

The patient was a man, aged 30, who presented lesions resembling lupus erythematosus involving the nose, the right shoulder and the interscapular region. There was an obscure history of a chancre some years previously, without subsequent manifestations until the present lesions appeared about four years ago. The gross appearance of these lesions was so like those of lupus erythematosus that the case, though probably syphilitic, was deemed worth showing to the members of the Society. There was a crusting lesion on the left arm due to vaccination.

DISCUSSION

DR. ORMSBY considered the case as one of syphilis of an interesting type. Not infrequently, there was a late syphilid which spread peripherally and was not made up of individual nodules. It scaled at the advanced margin, presenting a picture somewhat like that seen in ringworm. In this particular case, some of the lesions resembled the lesions of lupus erythematosus.

Answering the question of Dr. McEwen concerning the location of patches of erythematous lupus, Dr. Ormsby stated that he recalled the case of a woman who had lesions that extended some distance down the back between the shoulders, and also on the chest, which were of the classic discoid type of lupus erythematosus. In this case there were no lesions on the hands or forearms.

DR. SHAFFNER thought the interesting point of the case was that the man was vaccinated just two weeks previously and despite active syphilis, there had been no effect on the vaccination. He had been taught never to vaccinate in the presence of active syphilis for fear of producing a gummatous lesion.

DR. MCEWEN stated that the case was sent into the county hospital as a lupus erythematosus but it appeared to him to be syphilis. He had never seen a lupus erythematosus involving the nose with other lesions as far down on the back as this case presented. He asked if any of the members had ever observed a distribution of lupus erythematosus in these regions with freedom from lesions on other portions of the body.

SYPHILIS WITH ERUPTION RESEMBLING TUBERCULID. Presented by DR. PARDEE.

The patient was a man, aged 21, single, a Russian by birth, having been in America for five years. He presented an eruption which appeared first on the forehead three months previously, and a few weeks later extended to the shoulders, back, and a few scattered spots on the abdomen. At the same time a sore appeared on the penis which lasted two weeks (no treatment), and there was a history of a previous sore on the penis about eight years ago. A Wassermann test, March 19, gave a positive reaction.

DISCUSSION

DR. WILE thought one had to differentiate here between a syphilid and a folliclis, and that sometimes the diagnosis between these conditions was difficult. There were lesions in this case which were grouped and much like those of a follicular syphilid, and there were lesions on the body represented by pigmented scars which might have been due to syphilis but might as well have been due to a tuberculid. On the basis that this man had on his forehead lesions which were not syphilitic but which resembled those of acne varioliformis or acne necrotica, he believed the case was one of folliclis with incidental syphilis.

DR. ORMSBY said that syphilis had the ability to produce lesions that imitated many nonsyphilitic processes, and in view of the fact that syphilis was present in this case he would not be surprised to see the whole process clear up after antisyphilitic treatment was instituted.

DR. SHAFFNER said he had seen the case a week previously and the symptoms had cleared up remarkably since that time. He thought it was probably a papulonecrotic tuberculid on a syphilitic basis.

TUBERCULOSIS OF THE MUCOUS SURFACE OF THE UPPER LID CURED BY RADIUM. Presented by DR. PUSEY.

The patient was a man, aged 40, who had had tuberculous glands of the neck. An affection on the under surface of the upper right eyelid had been present for a long time. When first seen by the speaker there was a mass of excrescences which were slightly elevated and soft and showed a little ulceration; the diagnosis made by competent ophthalmologists was tuberculosis of the mucosa of the lid. He was treated with radium, applied to the under surface of the upper lid, with practically complete recovery. The speaker said he had often used radium covered with a rubber dam on the eye. He had treated an epithelioma on the conjunctiva with absolute wiping out of the lesion, and had

treated a similar lesion at the border of the cornea, giving twenty minute applications. He had also treated a number of lesions on the under surface of the lids in this way very satisfactorily. The applicator covered with rubber produced an erythema in twenty minutes on a normal skin

GRANULOMA PYOGENICUM OF THE LIP. Presented by DR. STILLIANS.

The patient was a man, aged 27, by occupation a clerk, in good health. Two months before presentation, after biting his lip he noticed that the skin paled, and soon afterward a small growth appeared which slowly increased. This was removed about three weeks before presentation by fulguration, but recurred.

The lesion was a flat topped papule 0.7 cm. in diameter and about 0.2 cm. high at the center of the lower lip, well inside the mucocutaneous juncture. The border was covered by epithelium but the center was composed of granulations.

DISCUSSION

DR. WILE thought the case was probably an infection similar to other cases which had been shown before the Society, and followed a trivial injury. It might be spoken of as an infected granuloma or some such banal infection.

DR. ZEISLER thought that the lesion might be a granuloma pyogenicum.

DR. STILLIANS believed it was a granuloma pyogenicum as the skin had grown up around the lesion, leaving a central lesion with the granulations showing in it.

URTICARIA PIGMENTOSA. Presented by DR. LIEBERTHAL.

The patient, aged 39, had been married twenty years, and had never been pregnant. As a girl she had always been well, but since she was married she began to suffer from habitual constipation and dysmenorrhea. About eleven years ago, in the summer, her face broke out, and soon after the eruption spread over the body. The latter showed remissions and exacerbations, independently of menstruation or season, and had never left her altogether. It burned and itched. She felt debilitated generally and complained of pain in cold and changeable weather.

DISCUSSION

DR. SHAFFNER said he had presented this case for the first time before the American Dermatological Society and the diagnosis then was an urticaria pigmentosa but the biopsy showed no mast-cells. The condition had not changed much; she had had some urticaria on irritating the skin, but no itching.

DR. ORMSBY said that he had shown a case of a similar type at the last meeting of the Society, which he considered an urticaria pigmentosa, and the biopsy in that case showed no mast-cells. He wondered if there were not two types: the juvenile type, in which the mast-cells were characteristic; and an adult type, in which there were no mast-cells. He thought that within a short time a report would be made on these two groups. He said that the type of lesion in this case differed from that presented in his case, but he believed it was an urticaria pigmentosa.

DR. STILLIANS thought it would be very difficult to separate the cases into two types. A case which Dr. Pusey had shown had begun in adult life and exhibited a large number of mast-cells.

DR. LIEBERTHAL believed Dr. Ormsby was right; in his estimation there were two types which differed from each other. The true urticaria pigmentosa was a disease beginning in infancy, and the urticaria perstans with pigmentation in later life. The absence of mast-cells did not exclude the diagnosis of urticaria pigmentosa. In the early literature a definition between the two types had been made. He said he had not made a thorough examination of this patient, but she was complaining of various gastro-inestinal disturbances.

pains, and of dysmenorrhea, and he intended to have her thoroughly examined in every respect and should not be surprised if she recovered after being subjected to systemic treatment.

WHITE SPOT DISEASE (?). Presented by DR. E. P. ZEISLER.

The patient was a man, aged 57, a laborer by occupation, who presented atrophic, white, scarlike spots on the chest and on the back which had been present for many years. The possible diagnosis of "white spot disease" was suggested.

DISCUSSION

DR. SHAFFNER believed the lesions were scars which had been present for many years and had flattened out considerably.

DR. ORMSBY thought the case was neither morphea guttata nor lichen planus atrophicus of Hallopeau. In guttate morphea the lesions had a slightly yellowish tinge, and a certain amount of thickening was present. There was also a tendency toward grouping. In the atrophic lichen planus, the lesions were dead-white and were composed of angular papules, in which black keratotic plugs were situated. In the present case, there was simply an atrophy, which apparently was the end-result of a long-past inflammatory process.

ALOPECIA. Presented by DR. ORMSBY.

The patient was a man, aged 43, who had a circular patch of partial alopecia on the scalp. The lesion appeared three years ago in a small area in which the hairs broke off, remained short and were atrophic. On treatment it seemed to improve. The hair grew a little and then the lesion recurred and had been about the present size for some time past. On presentation there was an area of partial alopecia the size of a silver quarter, in which atrophic hairs were present, each being about one-quarter inch in length. In the area intense itching was present.

DISCUSSION

DR. ORMSBY said the patient was shown before the meeting of the American Dermatological Association in 1914, and Dr. Jackson said the condition corresponded with two cases he had seen of atrophy of the hair, formerly undescribed. This was the third case of that type. He only knew it was atrophied from a clinical standpoint, as no microscopic work had been done. There had been no change in the condition in five years. The hair remained short and fine and he considered it an unusual case of atrophy.

CASE FOR DIAGNOSIS. Presented by DR. SENEAR FOR DR. PUSEY.

The patient, a man, aged 39, was first seen six days ago. The eruption had appeared about two days before that time, beginning with a patch of small reddish papules on the forearm. Gradually this eruption spread up and down from this point. The eruption was somewhat more erythematous when first seen. The patient had been using a 3 per cent. ichthyol ointment.

The eruption was striking because of its linear distribution. Consisting of small, reddish papules, or simply patches of dermatitis, it extended along the extensor surface of the arm and forearm and passed over the shoulder to the scapula. Here it split to form two broader branches, which passed across the scapula to the midline of the back at about the level of the sixth and seventh thoracic vertebrae.

DISCUSSION

DR. MCEWEN stated that he was unable to come to a definite conclusion, but had thought of the possibility of an atypical lichen planus, and, secondly, of a feigned eruption.

DR. SENEAR stated that they had not made a diagnosis at the office. He had gone into the question of a feigned eruption very carefully and was unable to get any confirmation along that line.

DR. HARRIS thought the case belonged to the same group as some patients shown previously by Dr. Quinn and himself. Most of the men thought it was a lichen planus, but he believed it was a linear dermatitis, or, as the Germans say, a "strichförmige" eruption.

CASE FOR DIAGNOSIS. Presented by DR. HARRIS.

In this patient, a man, aged 25, the condition began when he was 2 years of age. The eruption appeared and disappeared, occurring especially at areas of pressure. There was no subjective sensation. The patient was shown on account of the distribution of the lesions. The axillary folds, the bends of the elbows, a plaque on the abdomen where the trousers made pressure, and areas over the scapulae showed a thickening and brownish discoloration of the skin and some scaling.

DISCUSSION

DR. ORMSBY said that most cases of acanthosis nigricans were accompanied by some malignant neoplasm internally in the adult, but this was not true in the juvenile type. These cases recovered and were not accompanied by neoplasms. He cited a case he had seen when the patient was about 14, which was a classic case, and he saw the patient again six years later, when he had entirely recovered.

DR. WILE thought some of the members might have an idea that the case was one of acanthosis nigricans. He did not think it was, for although the clinical picture was one of parakeratosis and pigmentattion, the clinical picture, which we had definitely established for acanthosis nigrans, was an eruption of not such long standing as in this case, and almost invariably associated with malignant neoplasm. That picture should be kept as a separate entity. Furthermore, he did not think the eruption was sufficiently uniform to class it with acanthosis nigricans. The cases he had seen with Dr. Politzer, and one with Dr. Gilchrist, involved the trunk, the axillae, the scrotum and genitalia. The patient presented here had lesions on the backs of the hands. The speaker had no diagnosis to offer; his contribution was of a negative nature.

DR. HARRIS thought the diagnosis lay between two things, an arsenic eruption and an ichthyosis. The patient had a skin disease, which began when he was 2 years of age, and did not know whether he had taken any arsenic or any other medicine in the early stages.

HYPERKERATOSIS OF THE PALMS. Presented by DR. EISENSTAEDT.

The patient was a man, aged 32, who had had the condition of the palms since birth. There were four children in the family, the patient and one sister being affected; one brother and one sister were free; the mother was affected and one of her parents, the patient did not know which one. The lesions consisted of hyperkeratosis of the palms and soles.

DISCUSSION

DR. EISENSTAEDT said that under the free use of practically any salve the man kept his hands in sufficiently good condition to earn his livelihood.

PECULIAR DERMATITIS IN A LEUKEMIC. Presented by DR. STILLIANS.

The patient was a boy, aged 9 years, from the service of Dr. Strauch at Cook County Hospital. He had been getting roentgen ray treatments over the spleen and benzol internally for the past ten months for a splenomyelogenous leukemia. The skin eruption had been present only about two weeks. It consisted of sharply defined, dull red, hyperkeratotic and slightly scaly patches, very slightly

raised above the general level of the skin, located on the palms, soles, backs of hands and feet, in the bends of the elbows and knees and on their extensor surfaces, and beginning patches about the umbilicus and along the iliac crests. Behind the knees the eruption could be seen to occur along the lines of pressure, as the skin wrinkled on flexion. It was exactly symmetrical and caused no subjective symptoms.

DISCUSSION

DR. IRVINE thought the distribution of the lesions was somewhat unusual, but he had seen cases accompanied with this dermatitis in which the hands and feet were especially involved and the folds of the elbows and knees were very much worse than the rest of the skin; that is, there was a general dermatitis which was simply accentuated in these places. He believed it was a dermatitis accompanying a leukemia.

DR. MCEWEN asked if it was believed that the benzol had any relation to the eruption.

DR. SHAFFNER said he had thought of the possibility of pityriasis rubra pilaris in connection with the case.

DR. STILLIANS said that he had to thank Dr. Strauch for the loan of the patient. All were interested in the case as to the possibility that the eruption might be caused by the benzol. The drug had been stopped, as the reduction in white cells had reached a low enough figure for the present, and it would be interesting to watch the eruption after the cessation of medication. Dr. Hein, the intern on the dermatological service at the hospital, had looked up the impurities of benzol and found them to be anilin and nitrobenzol.

ALOPECIA. Presented by DR. SHAFFNER.

The patient was a woman, aged about 30, who presented a lesion of the scalp which had been present for about ten months. There was no ulceration and no other lesions on other parts of the body.

The lesion was an oval shaped patch of alopecia, with some telangiectasis and atrophy of the scalp, extending over an area about the size of a dollar.

DISCUSSION

DR. MITCHELL said the case appealed to him as one of syphilis.

DR. HARRIS thought it might be a case of morphea, as the lesion had an indurated border.

DR. ORMSBY thought it was either a linear morphea or a case of lupus erythematosus.

DR. MCEWEN agreed with Dr. Harris as to the probability of a morphea.

DR. SHAFFNER believed there was nothing against the diagnosis of a lupus erythematosus, but had never thought of morphea in connection with the case.

LUPUS VULGARIS. Presented by DR. HARRIS.

The patient was a man, aged 39, who had had lesions for fourteen years, which began on the upper lip. He was treated with the roentgen ray four years ago and the lesion disappeared but returned three years later at the site of the original involvement, and had been spreading for a year. The lesion consisted of an elevated papillomatous area with a spreading border, beginning at about the middle of the lower lip and extending around the side of the chin up to the left nostril and over the tip of the nose around and over the right nostril and beyond the upper lip.

DISCUSSION

DR. MITCHELL thought the case was a blastomycosis.

DR. BAER said the case impressed him as being a lupus vulgaris.

DR. IRVINE thought the lesions of the chin looked like a blastomycosis, but that one should also consider a lupus vulgaris.

DR. FOERSTER thought it was lupus vulgaris clinically, substantiated by Dr. Harris' negative findings as to blastomycosis. The case he had seen in negroes had been of the rapidly advancing type, differing from this one.

DR. HARRIS believed the case to be a lupus vulgaris.

LESIONS OF THE NOSE. Presented by DR. HARRIS.

The patient was a man, aged 27, a Syrian, who had been in this country for five years. One year after arrival the lesions of the nose appeared.

The disease consisted of a destructive, proliferative lesion of the septum, resulting loss of the entire septum, and some wartlike processes where it involved the cutaneous surface.

DISCUSSION

DR. MCEWEN thought the diagnosis was tuberculosis as against syphilis.

DR. WILE thought the case was one of tuberculosis, but there was something quite unusual about it. It had attacked the bony septum as well as the cartilaginous portion and resembled in its destructiveness a syphilitic process. The nodules right at the edge of the ulceration, he thought, were characteristic of tuberculosis.

DR. HARRIS believed the case to be a tuberculosis, with a reservation in favor of gangosa. On account of the patient being a Syrian, he thought a biopsy should be made.*

DR. ORMSBY stated that Dr. Mitchell had made some sections of the case which was presented before the March meeting as an adenoma sebaceum or a multiple benign cystic epithelioma and they were on exhibition. The sections were typical of multiple benign cystic epithelioma.

CASE FOR DIAGNOSIS. Presented by DR. SENEAR.

The patient was a boy, aged 11 years, who was having his annual attack of pruritus, which developed each year as soon as the weather was warm. He had had these attacks each year since birth and, according to the father, they cleared up as soon as the weather became cool in the fall. This attack had been present for about two months. There were no lesions, other than those due to scratching, when he was first seen, but there were numerous lesions with an urticarial element when presented.

DISCUSSION

DRS. SHAFFNER AND QUINN thought it was a lichen urticatus.

DR. WAUGH believed it was an urticaria. There were two or three fairly typical urticarial lesions to be seen.

DR. PUSEY said he could not agree with the diagnosis of lichen urticatus. That was a chronic urticaria of children, with which we had become familiar through descriptions of English dermatologists, the disease being very common in England. It was distinctly an urticaria. This case was a dermatitis from scratching, and the history was definite that it was a summer eruption, appearing in the spring and getting well when winter came on. He thought the case must be classed as a summer dermatitis—a dermatitis estivalis.

SYMMETRICAL KERATODERMIA. Presented by DR. E. P. ZEISLER.

The patient was a woman, aged 43, with a symmetrical keratodermia of the palms and soles, which began in early childhood. The palmar surfaces were markedly thickened, roughened and yellowish green. There was an inflammatory areola which spread to the sides of the fingers and knuckles. There was also

* The biopsy subsequently showed tuberculosis.

an associated hyperidrosis. The patient was married and had four children, none of whom had developed this condition.

DISCUSSION

DR. MCEWEN thought it was a remarkable case and wondered whether there was any possibility of an unrecognized source of arsenic poisoning.

DR. QUINN believed the duration of the lesions would rule out arsenic, as the woman had had the condition since childhood.

DR. HARRIS considered it a symmetrical keratodermia.

DR. MITCHELL said he had seen a boy with Dr. Ormsby several years ago who presented exactly the same condition on the backs of the hands, along with keratodermia, well defined and perfectly symmetrical, but in that case the lesions extended up further.

DR. PUSEY stated that he had some photographs of a case of keratodermia where the lesions extended well up on the sides of the hands and wrists, and thought the extent of the eruption in this case would not rule out the diagnosis of congenital keratodermia.

PARAPSORIASIS EN PLAQUES. Presented by DR. MITCHELL.

The patient was a little girl who was presented at the March meeting. She was shown again to demonstrate the results of treatment. She had been given nothing aside from sulphur and salicylic acid ointment, which was applied daily with almost complete disappearance of the lesions.

DISCUSSION

DR. MITCHELL said that when the patient was shown at the past meeting there was some discussion as to whether it was parapsoriasis en plaque or seborrheic dermatitis. She was shown again to demonstrate the results of treatment. The fact that the condition had yielded to a simple salicylic and sulphur ointment demonstrated that it was probably not parapsoriasis.

VITILIGO AND PIGMENTARY SYPHILID. Presented by DR. MCEWEN.

The patient, a woman, aged 17, was infected with syphilis about five months ago. On admission to the County Hospital, one month ago, there were numerous condylomata lata about the genitalia and the pigmentary changes about the neck, which were still present. These consisted of one or two large white areas surrounded by zones of hyperpigmentation, the whole being surrounded with a pigmentary mottling, which consisted of a mesh work of pigment enclosing islands of white skin; a similar appearance, in less degree, was present about the axillary folds.

The patient stated that when she was a child she had "eczema" on the neck, which left the large white areas. There was no evidence of atrophy.

The case was presented as an original vitiligo, complicated by a recent pigmentary syphiloderm.

DISCUSSION

DR. MCEWEN said that, according to the patient, the large white spots had been there as long as she could remember; when a child she had "eczema" on the neck and those spots were left. She said the other, namely, the mottled lesions, had appeared recently. When she entered the hospital she presented many condylomata lata and there was no doubt as to the syphilitic infection. He believed that the older spots were lesions of vitiligo, and that the more recently appearing macular changes were those of a pigmentary syphilid. He thought the case presented a curious and difficult problem in diagnosis.

DR. PUSEY agreed with Dr. McEwen's view that the leukoderma on the back of the neck, at the border of the hair, was distinct from the syphilitic leukodermia. He thought that the following question that Dr. McEwen had pro-

pounded was interesting and suggestive: Would a leukoderma in a patient predispose him to a syphilitic leukodermia? Patients with a leukoderma already had a pigmentary disturbance, and it was a fair surmise that with such a disturbance already existing, it might predispose the patient, if he acquired syphilis, to syphilitic leukoderma. The condition in this case reminded him of a somewhat similar combination which he had shown before the Society a few years ago. The man had alopecia areata and syphilitic alopecia. The combination in his case was conclusively established at the meeting by the fact that Dr. Anthony recognized the patient as one whom he had seen several years before with alopecia areata, before he had acquired syphilis.

DERMATITIS HEMOSTATICA WITH FOLLICULAR PURPURA

Presented by DR. E. P. ZEISLER.

The patient was a sausage maker by occupation, aged 39, who had had the eruption on his lower extremities, below the knees, for the past six weeks, and had a similar eruption a year ago. The lesions consisted of follicular purpuric spots and larger confluent areas of dermatitis around the ankles. There were associated varicose veins.

DISCUSSION

DR. MCEWEN believed the follicular hemorrhagic tendency could be explained on the ground of some internal condition, probably involving the kidney. He thought the remainder of the lesions were due to the varicose veins and the trauma from scratching.

DR. HARRIS thought it was a dermatitis of the nature of an eczema and accepted Dr. McEwen's suggestion of the possibility of kidney trouble. The peculiar thing about the case was the sharp outline of the patches, which looked as if there had been an old psoriasis. The man complained of intense itching, which would account for the follicular hemorrhage.

DR. MITCHELL said he had recently seen a patient who presented much the same lesions but not so pronounced, and in that case there was a severe nephritis. After rest in bed the condition cleared up very promptly, but reappeared after the patient was on his feet again for a short time.

DR. EISENSTAEDT said the hypostatic condition should be emphasized. The man was on his feet all the time, and that would have some influence on the trouble.

DR. PUSEY thought the case might be explained altogether on the bad condition of the circulation in the man's leg—a hypostatic congestion. He might have congenitally bad blood vessels which had become worse in the legs on account of constant standing. He thought it was not necessary to invoke a nephritis to account for the patches. As to the sharp outline, that was seen not rarely in hypostatic dermatitis.

CASE FOR DIAGNOSIS. Presented by DR. HARRIS.

The patient, a woman, aged 25, had had an attack of influenza about four months previously. After leaving the hospital a ringed eruption appeared on the right cheek, which at the time of presentation was about 4 inches in diameter. After the lesion on the cheek appeared she developed an eruption on the hand.

The lesion on the cheek had an erythematous outer border, the inside being somewhat lighter and showing slight scaling. On the fingers and hands were red, irregular spots, which appeared one month after the eruption on the face. There were some vesicles and telangiectases.

DISCUSSION

DR. MCEWEN thought it was an unusual case. His first diagnosis would be erythema multiforme, but he would want to be sure that syphilis was ruled out.

DR. QUINN believed it was an erythema multiforme of the hands, but thought the lesions on the cheek resembled lupus erythematosus.

DR. SHAFFNER considered it a toxic erythema.

DR. STILLIANS considered the case a lupus erythematosus because of the distinct scarring in some of the lesions on the fingers. The vesicles present would not rule out lupus erythematosus.

DR. MITCHELL said the case reminded him of that of a young lady from Iowa, who had perfectly symmetrical lesions on the palms and fingers and also on the face over the nose and cheeks, with a few lesions on the feet which were not symmetrical and were less marked. The condition had been present for more than a year and the general health was very good. There was marked circulatory disturbance of the chilblain type and the patient gave a mild reaction to tuberculin.

DR. WAUGH considered it an erythema multiforme.

DR. PUSEY was reminded of a case from Iowa, seen ten years ago, in which a woman who had tuberculosis also had lupus erythematosus on the face. On the hands the patient had an eruption which could only be described as a toxic erythema; it occurred particularly around the nails and was associated with a good deal of atrophy and destruction of tissue. He had seen a number of cases, which made him believe that lupus erythematosus was a toxic condition, analogous to erythema multiforme. He thought it was not an unknown picture to have erythematous lupus with vesicular lesions on the hands.

DR. HARRIS said he had not examined scrapings from the lesions, but he believed it was an erythematous lupus.

CASE FOR DIAGNOSIS. Presented by DR. MCEWEN.

The patient was a boy, aged 17, who worked in a box factory. He presented lesions which had appeared about seven weeks previously on the face and two weeks later on the hands. The lesions on the face had never presented the broken-down condition which was present on the hands. There were also lesions on the feet, buttocks, thighs and elbows.

The lesions consisted of papulovesicles, many of which were hemorrhagic and gangrenous. Those on the hands and feet showed depressed, crusted centers, which appeared very much like vaccine vesicles.

DISCUSSION

DR. HARRIS said when he first saw the patient the distribution of the lesions made him thing of an erythema multiforme. When he saw the lesions on the buttocks he thought of a dermatitis nodularis necrotica. He thought the condition of the face was originally the same as the other lesions.

DR. LIEBERTHAL thought it was a case of impetigo.

DR. QUINN considered it a pustular infection similar to a folliclis.

DR. MCEWEN thought the first thing to consider was an erythema multiforme with necrosis; then the possibility of a chronic tuberculid. He had seen somewhat similar conditions following measles and scarlet fever, but in this case no history of a recent infectious disease could be elicited.

DR. PUSEY thought he had never seen a necrotic lesion in an exudative erythema. He had seen hemorrhagic bullae, but had never seen the base undergo solution as in this case. He thought the case was not an erythema multiforme. The patient was poorly nourished and had a very bad peripheral circulation. He believed the case was one of varicelliform erythema developing in a bad skin, and was analogeous to the cases following measles and scarlet fever, but was not so acute as in those cases because it was due to a chronic underlying condition. The lesions on the backs of the elbows, he thought, would agree with this view. He had seen ecthyma on the legs, which was very much like this.

DR. WAUGH thought it might be a hydroa estivale.

DR. MITCHELL said if the lesions had been of a little longer duration, he would have thought of a tuberculid.

DR. STILLIANS was reminded by this case of a woman patient at Cook County Hospital, who had several large, deep areas of gangrene due to embolism. She died of miliary tuberculosis. The only case of so-called gangrenous erythema multiforme that he had seen was very superficial and had no lesions approaching in depth those of the case presented. He did not think the case an erythema multiforme.

ECZEMA. Presented by DR. QUINN.

The patient, a man, aged 46, was a native of England, a tinsmith by occupation, who had had the same trouble for thirteen years. The head, neck and arms were involved. There was an intense pruritus and most of the lesions were produced by scratching. He gave a history of persistent constipation.

DISCUSSION

DR. MCEWEN said the man was formerly a patient of Dr. Hyde's and he had seen him in 1911, when the condition was fully as bad as shown on presentation. The patient had stated that he attributed part of his trouble to the use of a sulphur ointment that was too strong. The speaker believed that eventually it would be found to be due to a staphylococcus infection, and that the best hope of relief lay in the making of a vaccine. The whole course of the disease had been analogous to several that had been treated at the Central Free Dispensary, in which the staphylococcus had been found and a vaccine prepared from the culture. Relief and cure had been effected by vaccination. He thought the case represented a group which was not clearly established as to etiology. In the old days it would have been called a dermatitis seborrheica.

DR. HURLBUT had seen the case a year ago, when it was much worse than at the time of presentation, but had never seen anything to suggest staphylococcus infection. It had been treated as an eczema.

DR. HARRIS thought it was a chronic eczema of a toxic origin. He thought there was probably some internal trouble which would account for it.

DR. PUSEY said he had seen many of these cases of chronic eczema of the face which were similar to each other. He agreed with Dr. Harris that they were chronic eczemas of toxic origin. He thought in time some of them would be put in a clinical group by themselves. He had always felt that they were due to some internal disturbance which was at present beyond discovery. He was interested in the staphylococcus idea: (1) that it was due to that infection, and, (2) that vaccines would cure it.

DR. QUINN said the man was constantly complaining of trouble with his bowels. He had seen him two weeks previously in the hospital, when he was much worse. He had been taking a bath every day and had been fed fairly well. He believed that most of the trouble was due to some gastro-intestinal disturbance.

CASE FOR DIAGNOSIS. Presented by DR. LIEBERTHAL.

The patient was a man, aged 32, a painter by occupation, married and the father of three healthy children. He had always been well except for an attack of typhoid fever three years ago and one of rheumatism last winter. He never was subject to skin diseases. About two years ago he noticed little red spots on the left cheek; the skin underneath soon became hard, the spots gradually increased in number and the hardening increased in extent in all directions. Swelling of the face appeared and increased in intensity; the left lower eyelid began to swell two weeks before presentation. There was no pain, spontaneously or on pressure, and there were no constitutional symptoms of any kind.

DISCUSSION

DR. HARRIS thought it was not an actinomycosis, but a cellulitis of the cheek, possibly due to some of the organisms in the mouth.

DR. PUSEY believed there was a focus of infection somewhere in the mouth or nose, and as a result he had the cellulitis of the face and was going on to a condition of "solid edema" of the face.

DR. LIEBERTHAL said he had seen the case two days previously for the first time. Actinomycosis could be ruled out; there was no infiltrated connection between the lesions on the face and on the neck; and in a case of two years' duration there should be some focus of softening. In cellulitis a continuous infiltration would be found and no separate lesions. The history revealed that at first there appeared swelling and red spots on the cheek. The latter became then diffusely red and very hard. A few months ago red spots appeared on the left side of the neck. Under some of them the skin and subcutaneous tissue was very hard; others again presented discoloration only. These indurated spots as well as the simple spots of the neck were separated from the infiltrated cheek by a broad band of normal tissue. The hardness and swelling of the cheek extended throughout all the tissues down to the mucosa.

The speaker suggested the diagnosis of scleroderma.

MANHATTAN DERMATOLOGICAL SOCIETY

Regular Meeting, April 13, 1917

FRED WISE, M.D., *Chairman*

LICHEN SCROFULOSORUM. TUBERCULOSIS CUTIS. Presented by DR. PAROUNAGIAN.

The patient was a male adult, who had been shown before the Society several times previously and who was again presented by the exhibitor, to let those gentlemen who had not seen the case observe the lichen scrofulosorum lesions of the body. The speaker said he wanted to get the opinion of some of the men about roentgen-ray therapy in the tuberculous condition of the nose.

DISCUSSION

DR. WEISS said he thought that lichen scrofulosorum lesions faded spontaneously.

DR. SATENSTEIN said he had examined tissue from this case and found a typical lichen scrofulosorum. It was a well known clinical fact that these lesions were more or less transitory. The last time the case was presented, the lesions were erythematous, which the speaker attributed to the salvarsan and iodids the patient was then getting.

DR. WISE said he thought it was the concensus of opinion that the roentgen ray should be used in cases of this type of verrucous tuberculosis of the nose.

ERYTHEMA PERSTANS FOLLOWING INGESTION OF PHENOLPHTHALEIN. Presented by DR. HOWARD FOX.

The patient, Mrs. J. T., aged 27, was born in Russia. She had always enjoyed good health previous to the present illness. Her menses began at 14 and had always been regular and normal. She had been married eight and a half years and had one living, healthy child of 7 years. Thirteen months ago her second child was born, but died two days after birth. She had suffered from time to time from an eruption that appeared suddenly as red, itchy, more or less elevated spots disappearing in about two days, and being followed by

persistent pigmentation. The first attack appeared before her last pregnancy. Two attacks occurred during this pregnancy. Before each of the last two attacks appeared, she stated that she had taken a single "Ex-Lax" tablet and that a minute or two afterward the eruption suddenly appeared. She did not remember whether the first two attacks had followed the ingestion of any medicine. After the first attack the lesions disappeared entirely in two days but after the subsequent ones, pigmented spots remained and had not disappeared up to the time of presentation. The number of spots also had increased with each successive attack. On examination she presented about sixty dark, brownish, rounded macules, varying from a bean to a silver dollar in size. The largest measured 2 inches in diameter. There was no infiltration, no evidence of scratching, no oozing and no anesthesia. Some of the spots were smooth, others slightly scaly. The patches were most profuse on the back. They were also present on the face, neck, arms, forearms, backs of the hands, chest, abdomen and thighs. The patient was a pronounced brunette with black hair and brown eyes. She was of medium height, appeared to be in good health and weighed 135 pounds. The urine showed nothing abnormal. The Wassermann reaction was negative. The report of the biopsy had not been received.*

DISCUSSION

DR. WALLHAUSER said he would like to ask whether any of the gentlemen present had ever noticed a reaction following phenolphthalein. He had used it very extensively, but had never noticed any ill effects.

DR. SATENSTEIN said he had seen a number of individuals with practically the same type of lesions: erythematous lesions, which later took on the picture of an erythema multiforme iris. The lesions slowly retrogressed and the inflammatory symptoms disappeared, leaving pigmentation. When a recrudescence occurred, it was always at the site of the original lesion. Biopsies of these cases, studied very carefully, revealed absolutely no evidence of an urticaria pigmentosa, namely, mast cells, but a picture of erythema perstans with free pigment.

DR. WISE said, as Dr. Satenstein had stated, he thought this condition erythema multiforme, in which the patches, instead of involuting, did not resolve. The histologic picture resembled that of erythema multiforme. The speaker said the question of recrudescences, occurring in exactly the same spots, was interesting, but that the lesions also occurred aside from the old spots. He did not think the phenolphthalein was the causative factor. The five patients seen at the Vanderbilt Clinic gave absolutely no history of ingestion of coal tar products. The etiology was obscure. He would diagnose the condition as erythema maculatum perstans.

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* The following histologic report was made by Dr. Heimann subsequent to the presentation of the patient:

Save for a slight general edema the epidermis shows no noteworthy alterations. In the papillary body and the region of the subpapillary plexus, however, there is a distinct, though not intense, edema, causing a separation of the collagen fibers, the blood and lymph vessels are widened, and there is an infiltration. Under higher magnification the infiltration is seen to be within the lymph spaces, especially those surrounding the blood capillaries. This infiltration consists of round cells of the lymphatic type, fibroblasts and pigment cells. Those last mentioned are chromatophores and none of the pigment is of blood origin as is shown by the Perls stain. The chromatophores are seen in greatest number in the immediate vicinity of the vessels, but others are present at more removed points. Absolutely no mast cells are found. Thus urticaria pigmentosa may be excluded. The picture is one of a lymph edema with hyperpigmentation, corresponding to the appearance of erythema perstans.

DR. HOWARD FOX said he did not think that urticaria pigmentosa could be considered in this case. He had certainly never seen this disease occur in the large plaques presented by this patient. Furthermore, it was not possible to artificially produce wheals by friction on the lesions. Attention was also called to the rarity of urticaria pigmentosa in adults.

SCLERODERMA. Presented by DR. BECHET.

The patient was an adult woman from the service of Dr. Trimble. The disease came on rather rapidly, for in a few months she developed large plaques, irregularly scattered over the trunk. When first seen the disease had been present for sixteen months. She presented for examination large, hardened, boardlike areas, from 6 to 10 inches in diameter and of a waxy color, and there were no violaceous borders. The arms and legs were not involved. The patient was presented because of the very marked improvement following the administration of pituitary gland extract. The places were much softer and had lost much of their waxy color.

DISCUSSION

DR. WEISS said, in reference to this discussion, that the administration of pituitary and thyroid in scleroderma, although largely empirical; was not lacking in histopathologic and physiologic facts. Postmortem investigations had frequently shown the thyroid gland diseased, in cases of scleroderma and Graves' disease. But there were cases of scleroderma where Graves' disease was not present and the thyroid gland showed signs of atrophy. In such cases one was constrained to assume that there must have been a presclerodermic stage—the edematous stage of scleroderma, with symptoms of Graves' disease. Later on, with the development of atrophy of the thyroid, the real sclerodermic changes had taken place. This patient showed thyroidal markings of hypofunction and related symptoms of previous hyperthyroidism. Every alteration of the thyroid, it was held, might cause scleroderma and it was believed that the pituitary played a rôle in scleroderma only when the thyroid was not functioning properly. Compensatory hyperplasia took place in an endëavor to establish endocrin equilibrium. This reasoning explained the empirical administration of these two glandular extracts in scleroderma.

DR. BECHET said it seemed to him this case was one of scleroderma and not morphea. While morphea and scleroderma were practically synonymous, he preferred using the former term to designate smaller lesions, with telangiectatic peripheries. The lesions in the case presented were too extensive, and lacked the violaceous border. For these reasons he would prefer to call it scleroderma. The term scleroderma circumscriptum might be the most appropriate designation in cases similar to the one presented.

DR. WISE said he had seen this case one year previously, with the typical, boardlike morphea and there was no question about the diagnosis. He would call it scleroderma.

DR. GOTTHEIL asked whether they accepted this case as one of transitory scleroderma.

DR. GEORGE HENRY FOX said that clinically scleroderma and morphea were so distinct that he thought the old terms ought to be retained, in place of localized and general scleroderma.

DERMATITIS HERPETIFORMIS FOLLOWING VACCINATION. Presented by DR. HOWARD FOX.

The patient, A. M., was a girl, aged 6 years. She had been vaccinated for smallpox in March, 1915. About ten days later a generalized eruption of the erythema multiforme type appeared. From that time she had had numerous attacks and had never been entirely free of lesions. At times the attacks were

of the iris type of erythema multiforme. On other occasions the eruption was of the extremely itchy, papular type of dermatitis herpetiformis, while at times it also resembled prurigo.

DISCUSSION

DR. GOTTHEIL said he had seen this case a few weeks previously, with a typical erythema bullosum of both palms, which were covered with large bullae and typical erythema multiforme lesions of the backs of the hands.

DR. OCHS said he had seen this patient originally right after vaccination and at that time it was a typical case of erythema multiforme. That cleared up and then she started to get an attack on the arms which looked very much like prurigo. She had every spring and fall corresponding redness of the skin, when she got these attacks. She never had them before she was vaccinated. The speaker said Dr. Fox happened to visit the clinic and he showed him this patient and Dr. Fox made a diagnosis of dermatitis herpetiformis. Right after that it cleared up and she got another attack. The speaker said he had seen this patient with seven or eight separate, distinct attacks.

DR. GEORGE HENRY FOX said that in regard to the diagnosis, one thing to bear in mind was that in erythema multiforme there were never any excoriations as in this case, while, on the other hand, in dermatitis herpetiformis, there were occasionally erythematous disks with bullous lesions as in typical erythema iris. As both of these clinical appearances had been present at times in this case, he would call it dermatitis herpetiformis. Erythema multiforme would not cover the appearance of the case as presented.

DR. HOWARD FOX said that the case was of interest on account of the possible relation between the eruption and vaccination for smallpox. It was also of interest on account of the variation in the clinical picture which she had presented from time to time.

DR. GEORGE HENRY FOX said that one of the characteristics of dermatitis herpetiformis was its chronic, relapsing character, clearing up and new lesions coming out. He had never seen it limited to the backs of the hands but had seen cases of undoubted dermatitis herpetiformis, in which erythematous disks came out on the body.

BAZIN'S DISEASE. Presented by DR. KINGSBURY.

The patient was a woman, aged 19, who showed lesions of Bazin's disease, which were rather marked, but of comparatively short duration, having been present only six months. She had tuberculous glands at the left side of the neck and had been treated at the hospital with injections of iodin. The exhibitor believed the eruption appeared on the leg after the iodin injections. Both legs were affected, the anterior surfaces being the worse. There were a few nodules on the thighs.

HYPERTRICHOSIS. Presented by DR. GILMOUR.

M. S. A., woman, aged 30, married, was a housewife by occupation and had been born in Italy. The condition described was accidentally discovered while giving her an intramuscular injection of mercury salicylate for the treatment of syphilis. The patient was born with a growth of soft hair, a few inches long, situated over the small of the back. This had gradually increased in length and become coarser, so that it was like the hair of the human head. This hair was growing from a perfectly normal skin. There was no pigmentation or sign of nevus. About every twelve months, for the last eight or ten years, the patient had cut off this hair. The hair present at the time she was shown was 8 inches long and had been growing for one year. The growth had never been much longer than at the time of presentation. The space covered by the hair had a diameter of from 4 to 5 inches. The patient was of a highly neurotic type.

DISCUSSION

DR. GOTTHEIL said there was apparently no defect of the bony structure of the spinal column and certainly no affection of the musculature. He thought the localized hypertrichosis there associated with other defects, which pointed to an incomplete spina bifida.

DR. HOWARD FOX said he had previously presented a similar case before the academy section. This condition of congenital hypertrichosis was well known and was generally associated with spina bifida. In his case the mental condition was decidedly lowered.

DR. GILMOUR said he would try to get a roentgenogram of the spinal column, to see if there was any other condition present resembling spina bifida.

LUPUS TUMIDUS. Presented by DR. OCHS.

The patient was a woman, aged 38. The exhibitor said she spoke only Italian, so he unfortunately could not get a very good history of her condition. The patient had come from Fordham University and presented a lesion on the nose, which had been there between two and three years. It was slowly growing larger, was a soft mass and was shown as a case of lupus tumidus.

MOLLUSCUM FIBROSUM. Presented by DR. BECHET.

The patient, a man, aged 53, came from the service of Dr. Trimble at the University of Bellevue Clinic. The lesions began when he was 13 years old, so that their duration had been approximately forty years. The greater number of them had developed in the first decade, very little increase in number having been noticed in the past twenty years. The body was almost covered with an enormous number of pea to bean-sized, and larger tumors, in varying stages of development. The face was greatly involved.

DISCUSSION

DR. GEORGE HENRY FOX said that the name, molluscum fibrosum, on account of a suggested relationship to molluscum contagiosum which did not exist was changed years ago to fibroma molluscum.

D. L. SATENSTEIN, M.D., Secretary.

Review of Dermatology and Syphilis

Under the direction of Fred Wise, M.D., New York
Assisted by

Paul E. Bechet, M.D., New York
W. H. Guy, M.D., Pittsburgh
Robert C. Jamieson, M.D., Detroit
M. F. Lautman, M.D., Hot Springs
A. W. Stillians, M.D., Chicago
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THE BRITISH JOURNAL OF DERMATOLOGY

(April-June, 1917, 29, Nos. 4-6)

Abstracted by I. Rosen, M.D.

A CASE OF MULTIPLE ULCERATING BASAL-CELL EPITHELIOMA WITH ZONIFORM DISTRIBUTION AND POSSIBLY OF SWEAT GLAND ORIGIN. H. G. Adamson, p. 81.

The author's case is unusual on account of its zoniform distribution. Clinically the growths resembled ulcus rodens. Microscopic examination showed distinct basal-cell epithelioma, arising from the sweat ducts and glands.

The patient, when first seen in March, 1916, presented an irregular disklike patch about three-fourths inch in diameter and slightly raised above the level of the skin. It had an ulcerated crust in the center and a narrow nodular margin. This had been present for four years. The patient received massive doses of roentgen rays after which the lesion healed, leaving a smooth scar.

About six months later the patient returned with fresh lesions along the margin of the scar, together with new lesions extending upward and backward for several inches from the site of the original nodules. Some of the nodules were isolated, others were grouped and some coalesced, slightly raised, smooth, firm, and the color of the skin. The larger nodules showed ulceration with a central crust; their margins suggested the rolled edge of rodent ulcer.

SOME RECENT EXPERIENCES WITH PURE COAL TAR´ (PIX CARBONIS PREPARATA. B. P.) AT A BASE HOSPITAL IN FRANCE. H. C. Semon, p. 83.

Semon uses a combination of equal parts of pix carbonis, acetone and collodion, in scabies, seborrhea, psoriasis, lichenification, and eczema marginatum, with excellent results.

It is simple, safe, cheap and valuable in the chronic dermatoses of the pruritic type. No dressings are required, which is conducive to the patients' comfort.

ACTION AND RÔLE OF COLLOIDS IN CHEMOTHERAPY. J. E. R. McDonagh, p. 93.

TREATMENT OF SCABIES BY SULPHUR FUMIGATION. John Bruce, p. 100.

For this treatment the author uses a sort of improvised Turkish bath cabinet, so constructed as to hold two patients. As it is necessary for the cabinet to be

used out of doors, a canopy covered with canvas is used as a protection from the sun and rain. The seat is so constructed as to allow the sulphur fumes to penetrate to the buttocks.

Sulphur candles are used; they burn slowly and last for about five hours; each candle therefore is sufficient for the treatment of ten patients. As sulphur vapor acts more powerfully in the presence of moisture, a small basin with water is placed on a tripod over the candle. The patient should be kept warm during his stay in the cabinet so as to encourage sweating. The temperature inside the cabinet should be kept at 100-106 F. The exposure to the vapor should be from forty to fifty minutes.

Before the patient is placed in the cabinet, he is given a hot bath, well lathered with soap for at least five minutes; this opens the burrows. He is then transferred to the warm cabinet, the head protruding through the aperture in the roof, and a warm wet towel is placed around the neck to prevent the escape of fumes. An orderly must remain in constant attendance with instructions to remove the patient at once should he show signs of faintness or difficulty in breathing. At the end of forty to fifty minutes the patient returns to the bath room and puts on clean clothing.

One treatment is often sufficient to cure the old standing cases, but to be on the safe side, a second treatment is given at the end of forty-eight hours.

(July-Sept. 1917, 29, Nos. 7-9)

SKIN DISEASES AND THEIR TREATMENT UNDER WAR CONDITIONS. HENRY MACCORMAC, p. 169.

Unusual types of skin diseases have arisen during the progress of this war, for the environment of an army in the field, with its complicated trench work, is quite different from that of ordinary civil life.

The work of the dermatologist is important, when so large a number of men are gathered, for the control of contagious skin diseases. The best results are obtained in fixed institutions with expert personnel. There should be a scabies station for each army corps, where each special medical officer can cope with a large number of skin diseases. Regular medical inspection is necessary to weed out the early cases. The cases of scabies seen in France differ in some important features from those seen in civil life. The hands are often entirely free from lesions, while the interdigital burrows, often considered a pathognomonic sign, are present only in about 13 per cent. of the cases.

Pediculosis, a common affection among soldiers, presents a close resemblance to scabies, at times most puzzling to differentiate. Fortunately the penis is very rarely affected in pediculosis, while in scabies almost always. Interdigital vesicles rather than burrows should be sought for; impetigo of the buttocks is pathognomonic of scabies, and every patient with boils should be regarded as suspicious.

In the treatment, three conditions must be fulfilled: burrows must be opened to permit access of the parasiticide to the insect and ova; the parasiticide should be of such a nature as to destroy the parasite without producing a dermatitis, and, lastly, to prevent reinfection, contact clothing and blankets must be disinfected. The first of these conditions is achieved by a hot bath, soap, and a soft brush; the second, by the application of sulphur ointment, twice daily, for three consecutive days, and the third, by means of steam pressure or sulphur vapor apparatus.

PYODERMIA OF PARASITIC ORIGIN. H. C. SEMON AND H. W. BARBER, p. 173.

Pyodermia among soldiers, occurring on the trunk and limbs, is almost invariably due to a concomitant parasitic infection (scabies or pediculosis). The

authors describe in detail the differential diagnosis of the various parasitic diseases causing pyodermias, and in their conclusions emphasize the following:

1. Of 669 cases admitted in five weeks, 442 were directly due to scabies and pediculosis. It is therefore evident that the disability produced by parasitic infections is considerable.

2. The pediculus vestimentorum can, and in a great majority of the cases does, lay its eggs in the hair of the pubis and perineum, and sometimes in the axilla. It may therefore be deduced that measures directed toward sterilization of the clothes cannot be efficient, unless the host himself is disinfected at the same time.

3. A seborrheic diathesis greatly aggravates the infection.

CONCERNING THE LUETIN REACTION AND THE EFFECT OF IODIN. N. C. Borberg, p. 190.

A REMARKABLE CASE OF XANTHOMA TUBEROSUM MULTIPLEX. E. Parkes Weber, p. 202.

PROCEEDINGS OF THE ROYAL SOCIETY OF MEDICINE

(July, 1917, 10, No. 9)

Abstracted by W. H. Guy, M.D.

SKIN DISEASES AND THEIR TREATMENT UNDER WAR CONDITIONS. Henry MacCormac, p. 121.

A very interesting article dealing with contagious skin diseases in general, and with scabies and its complications in particular. Stress is laid on the occurrence of great numbers of cases of "the itch" in trench life and on the inefficiency of treatment formerly applied. The author states that of 1,000 cases diagnosed as scabies, boils, impetigo, over 65 per cent. are due to scabies, and after reviewing these cases and the results obtained by the usual treatment applied by untrained men he insists on the necessity of a special corps and scabies stations for the treatment of scabies, the personnel of each corps to include a dermatologist and trained assistants. Hot baths followed by sulphur ointment and disinfection of clothing for three successive days is recommended for routine treatment. Ecthyma, impetigo contagiosa, impetiginous seborrhea, pityriasis rosea, psoriasis, etc., are reported as of frequent occurrence among the troops; various etiologic factors and methods of treatment in vogue are discussed. Several excellent plates accompany the article.

CASE OF MACULO-ANESTHETIC LEPRA, George Pernet, p. 157.

CASE OF SYRINGOCYSTOMA. J. L. Bunch, p. 162.

CASE OF XANTHOMA TUBEROSUM MULTIPLEX. F. Parkes Weber, p. 164.

CASE OF DYSIDROSIS. J. M. H. MacLeod, p. 168.

A case of dysidrosis in a girl, aged 14, who was suffering from a hemiplegia. Of particular interest was the fact that the dysidrosis was much worse on the paralyzed side.

MACULAR ATROPHY OF THE SKIN. F. Parkes Weber, p. 175.

Due to the fact that this patient had a macular atrophy associated with a vitiligo, the author suggests the possibility of a common etiology for the two conditions.

BOLETIM DA SOCIEDADE BRASILEIRA DE DERMATOLOGIA

(Year 1915, 4, Nos. 1, 2 and 3)

Abstracted by V. PARDO, M.D.

This number of the Brazilian bulletin contains the proceedings of the sessions of the Brazilian Dermatological Society, from May 7, 1915, to December 24, 1915. Very interesting and notable cases are presented, among which those of myasis linearis (creeping eruption), granuloma venereum, leishmaniosis cutis, blastomycosis, yaws, and tropical ulcers, are the most remarkable. Also very interesting are two cases of late hereditary syphilis with enormous destruction of the face, presented by Dr. Machado, and several cases of annular syphilides in negroes, presented by Dr. Araujo. Dr. Roquette reported in the session held on June 9 the presence, in the Brazilian Indians of Juruema Valley, of a new disease which they call "aancé-dutú." It consists of vesicular and squamous lesions arranged in rings and seated on any part of the cutaneous surface. Roquette thinks that these lesions are produced by a fungus analogous to that of tinea imbricata.

I do not hesitate in recommending this bulletin to the readers of this publication and especially to those interested in tropical skin diseases. The reports are printed in French and Portuguese.

MUENCHENER MEDIZINISCHE WOCHENSCHRIFT

(Sept. 19, 1916, 63, No. 38)

Abstracted by ARTHUR WILLIAM STILLIANS, M.D.

ACNE NECROTICA AND THE USE OF TOBACCO. F. WEINBRENNER, p. 1372.

The author reports eight cases of acne necrotica, all in men who used tobacco, and all persistent until tobacco was stopped, when all except one promptly cleared up. The one case in which the treatment failed was in a chewer who had also a chronic stomach disturbance, which the author thinks may have kept up the disease. The claim is not made that tobacco is the only cause of the disease, for it occurs in women as well as in men, but it seems to have been the cause in these seven cases. Not only did the lesions disappear within a few weeks after the tobacco was given up, but in one of the cases they recurred when tobacco was again used. Local treatment consisted of diligent washing with alcohol.

A COMMUNICATION ON THE TREATMENT OF FURUNCLES IN TROOPS IN THE FIELD. F. KASTAN, p. 1372.

After trying out various methods and combinations of methods, the author decided that a thin but continuous coating of blue ointment about the lesions, with a wet dressing of weak aluminum acetate solution on them, is by far the most effective. The wet dressings are renewed daily, but the ointment is left on for three or four days at a time. When many lesions are present and the ointment is spread over a large surface it must not be used too long for fear of mercurialization.

(Ibidem, Sept. 26, 1916, 63, No. 39)

RESEARCH ON SPOTTED FEVER. H. DA ROCHA-LIMA, p. 1381.

The researches of Ricketts and Wilder, Prowazek and Sergent, Foley and Vialette are briefly reviewed. The author agrees with Ricketts and Wilder, that the polar staining bacilli are found constantly in lice fed on the blood of typhus

patients, but also occasionally in normal lice. The research of the author has resulted, however, in finding changes in the cells of the digestive tract of the typhus lice, secondary to the growth of the bacilli. No such cell changes were found in normal lice. The possibility that the intracellular growth of the bacilli was caused by the febrile temperature was ruled out by finding no such development in lice fed on the blood of other febrile diseases. The author believes that the organism is probably the cause of typhus, and suggests the name *Rickettsia Prowazeki* for it. Guinea-pigs injected with emulsions of infected lice sicken and acquire an immunity against typhus just as do animals injected with typhus blood. He thinks that the typical forms are the handle and biscuit shapes seen usually in the cells, and that the polar staining bacillus form is probably the result of a reaction in the cell. The organism is not the same as the much plumper and larger anaerobic bacillus of Plotz, which is gram-positive, while the *Rickettsia* decolorizes at once with Gram's solution. While he praises highly the careful research of Plotz and his co-workers he rejects the complement binding and agglutination tests as not necessarily specific.

HAMSTER COMPLEMENT IN PLACE OF GUINEA-PIG COMPLEMENT IN THE WASSERMANN REACTION FOR SYPHILIS. A. Reinhardt, p. 1399.

Because of the scarcity and high price of guinea-pigs the author has made a careful trial of the serum of the hamster (a small rodent) in place of that of guinea-pigs, and found it perfectly satisfactory. He suggests that other rodents, such as moles, may also furnish complement.

A CASE OF SYPHILITIC REINFECTION. Berent, p. 1408.

A case of primary syphilis with the Wassermann reaction still negative was given a total of 4.5 gm. of salvarsan-natrium between March 24 and May 1, 1916. The patient was then discharged as cured. He returned on June 20 with a history of exposure three or four weeks previously and two small ulcers, typical chancres, on the inner surface of the prepuce, from which many *Spirochaetae pallidae* were obtained. The primary lesions of the first infection were many, on a different part of the inner surface of the prepuce and on the glans and in the corona. The glands of the first infection were as large as hazel nuts, in the right groin. On the grounds of a history of exposure, different localization of the chancres and of the glands, and the negative Wassermann reaction in both cases, the author believes that the demonstration of a reinfection is sufficient. This is the first case of reinfection after a cure with salvarsan-natrium reported, so far as the author knows.

(Ibidem, Oct. 17, 1916, 63, No. 42)

ON THE TREATMENT OF HEMANGIOMA. K. Stromeyer, p. 1480.

In none of the descriptions in the literature of the alcohol injection method of treatment for angioma could the author find any mention of the advantage of compression of the tumor before and during the injection. This eliminates the diluting effect of the blood in the vessels, and increases the proportion of connective tissue to the whole mass of the tumor, so that the injection can be made into the extravascular tissue much more easily. The number of treatments necessary to a cure is thus reduced from many to from two to five, he claims.

TUBERCULOSIS OR SYPHILIS OF THE LUNG? Wilmans, p. 1481.

The importance of careful diagnosis, with the possibility of pulmonary syphilis of the adult in mind, is emphasized, and the diagnostic points are reviewed. Eight cases of pulmonary syphilis are reported.

ON THE CHOLIN CHLORID TREATMENT OF SCARS AND THEIR RESULTS. O. BURKARD, p. 1505.

In thirty-seven cases of scarring, none of which were beyond the hope of improvement, the author has seen no results whatever from the injection of cholin chlorid, which Fraenkel has so highly recommended. The injections have done no harm except in causing the pain, which is not inconsiderable.

(*Ibidem, Nov. 28, 1916, 63, No. 48*)

THE CAMPAIGN AGAINST VENEREAL DISEASE. VON ZUMBUSCH AND DYROFF, p. 1692.

The report of a commission appointed by the medical society of Munich. They believe that the great need is for measures compelling infected persons to take adequate treatment. The familiar argument that the attempt at compulsion would lead to concealment and treatment by quacks is not necessarily true, according to the authors, who think that the knowledge of the danger from venereal disease which the legal act of compulsion would carry with it would offset this tendency. Of course the practice of quacks must be regulated. By their investigation they find that a large part of the population is in favor of legal compulsion. The argument that the physicians themselves would not heed the law is a slander on the profession. It is an encouraging fact that the laws already passed, though lacking the means of compulsion, have been well received by the people. They then present proposed plans for reporting cases, strict secrecy of records, examination of persons suspected of venereal disease or exposed to infection, and hospital treatment for the careless, rebellious and seriously ill.

TREATMENT OF ERYSIPELAS WITH QUARTZ LAMP. F. KOENIG, p. 1702.

The author remarks the scarcity of erysipelas among the wounded in the field, and the great frequency with which it occurs among the same class of cases in the home hospitals. The disease is not more severe than formerly, but the weakened condition of the soldiers makes it more dangerous for them than for others. Any method of treatment that promises to shorten the course of the disease is therefore gladly welcomed. Of late the treatment with ultraviolet light produced by the quartz lamp has been praised as far excelling all other methods in its effect on erysipelas. The author has been using this method since 1913, and at first was very enthusiastic in its favor, but soon encountered cases in which the progress of the disease was not at all arrested by the reaction due to the light. This is the same experience that follows the trial of any new method of treatment of this disease. Like all other methods, it fails in certain cases, and no claim for a sure cure can be made. The author has rayed cases after operation to prevent the development of erysipelas in the wound, but has seen erysipelas develop in spite of the effort at prophylaxis. In a case of compound fracture of the bones of the foot in which a Pirogoff osteoplastic operation was necessary three weeks' treatment with the quartz lamp failed to rid the wound of streptococci.

The article closes with a protest against the furor for ultraviolet light treatment, and mentions a case of gallstones in which it was used, and still worse, a case of carcinoma of the rectum treated with quartz lamp for three months, until inoperable.

(*Ibidem, Jan 2, 1917, 64, No. 1*)

A SEROCHEMICAL REACTION IN SYPHILIS. C. BRUCK, p. 25.

For years the author, a collaborator of Wassermann in the complement binding reaction for syphilis, has tried to find a simple substitute for it. He could not rid his mind of the idea that the reagin responsible for the Wassermann reaction

can be demonstrated in some simple chemical reaction if only the right reagent could be found. A study of the effect of oxidizing and reducing agents on syphilitic and nonsyphilitic serum produced no result. When he came to study the effect of acids and alkalies, however, he found that the nitric acid precipitate in syphilitic serum dissolved with greater difficulty on neutralization with alkalies than that in normal serum. Then he discovered that the precipitate in normal serum dissolved in water, while the syphilitic precipitate did not. On this fact he bases his new test.

To 0.5 c.c. of clear serum he adds 2 c.c. distilled water and shakes the mixture. To this he adds 0.3 c.c. of the acidum nitricum purum of the German Pharmacopoeia (about 25 per cent. nitric acid, with a specific gravity of 1.149) and shakes up the white precipitate. After allowing this to stand at room temperature for ten minutes, 16 c.c. distilled water is added and the tube (a large caliber test tube) is capped with the finger and carefully inverted three times, the formation of froth being avoided. After ten minutes, this mixing is repeated, and the tube left standing at room temperature for a half hour. At the end of this time the reaction can be read. All tubes with clear contents, or transparent opalescent contents are negative. Tubes with distinct, finely flocculent clouding are positive. After twelve hours the normal serums show clear, or with only a slight trace of precipitate at the bottom, while the syphilitic serums show a larger or smaller gelatinous precipitate.

Precautions:

1. Use only absolutely clean glassware.

2. Inactivation of serum is not necessary. Active or inactivated serum reacts the same.

3. If one has plenty of serum, 1 c.c. can be used with 2 c.c. distilled water, 0.3 c.c. reagent and 16 c.c. distilled water, or if the amount of serum is small, 0.3 c.c. serum can be used with 2 c.c. distilled water, 0.3 c.c. reagent and 14 c.c. distilled water.

4. Accurate dosage of the reagent is necessary; 0.2 c.c. gives negative reactions in syphilis, 0.5 c.c. positive reactions in normal serums.

5. Avoid reading as positive tubes showing moderate opalescence.

6. Avoid heating. The precipitate dissolves easily with heat.

7. Do not make more than twelve tests at once, in order to observe strictly the time between addition of reagent and dilution with water. Use a known positive and known negative serum as controls.

8. Strongly chylous, bloody or hemolytic serums are not to be used. Clear serums react the same after standing for days.

In 200 syphilitic serums the new reaction agreed with the Wassermann test in all but five cases. Two secondary cases and one latent, with positive Wassermann reactions, were negative to the Bruck test. One case of congenital syphilis and one with gumma of the palate, negative with the Wassermann reaction, were positive with the Bruck test. Cases giving doubtful Wassermann tests were either frankly positive or negative with the new test, always in accord with the clinical findings.

In 200 nonsyphilitic cases, five were positive by the new test, four of them being old wounds of the leg and thigh and one case of tuberculosis; these patients were all febrile.

The author does not expect his reaction to take the place of the Wassermann test, but thinks it may be due to the same peculiarity of syphilitic serum which produces the Wassermann reaction, and asks that it be given a trial by serologists. If it proves reliable, it has the great advantage of simplicity and shortness, requiring only a simple laboratory equipment and only one stable reagent. Any additions to our equipment for the diagnosis of syphilis will be especially valuable during the coming demobilization of the troops.

THE RECOGNITION OF *RICKETTSIA PROWAZEKI* IN CASES OF SPOTTED FEVER. H. DA ROCHA-LIMA, p. 33.

The proof of a bacterium-like parasite in the cells of lice fed on typhus patients, the fact that only in these lice can the organism be found within the cells of the gastro-intestinal tract, that normal lice become infected with this parasite when fed on typhus patients, that lice are infected with this parasite in no other way and that a strong relation exists between the ability to infect animals with typhus and the ability to infect lice with this parasite, make a strong chain of evidence in favor of this organism (the polar staining bacillus of Ricketts) as the cause of the disease. The fact that the organism cannot as yet be grown on artificial mediums and the further fact that it has not yet been demonstrated in the human tissues remain in the way of final proof of its specificity. The difficulty in demonstrating the organism in human tissues depends on the fact that granulations and tissue fragments exist in blood and other tissues that resemble the organism so closely in size, shape and staining (staining red with Romanowsky-Giemsa) that it is impossible to state definitely which is organism and which tissue fragment. He therefore rejects the claims of Toepfer and Hanser, that they have demonstrated the organism in skin sections.

AMERICAN JOURNAL OF THE MEDICAL SCIENCES

(October, 1917, 154, No. 4)

Abstracted by R. C. JAMIESON, M.D.

SYPHILIS OF THE NERVOUS SYSTEM IN SOME OF ITS CLINICAL AND PATHOLOGICAL MANIFESTATIONS. WM. G. SPITLER, p. 523.

The writer states as his belief that tabetic ocular palsies have lesions in the nerve fibers as they leave the brain, and that nuclear changes are more apt to be found in cases of long standing.

Degeneration occurring in the nerve is expected to return to normal provided treatment is vigorous and early and the degeneration not too intense. Degeneration of the cells of origin would show less improvement.

He discusses ocular nerve conditions in relation to syphilis and the connection between syphilis and epilepsy.

RESEARCHES IN REGARD TO THE COAGULO-REACTION OF THE SYPHILITIC SERUM. HISAKIYO UEMURA, p. 533.

The rather elaborate technic of this reaction is thoroughly discussed by the author and tables showing the results with 500 serums are given. He thinks this coagulo-reaction is highly characteristic of syphilitic serum if this technic is used and sources of error avoided. Although it may be superior to the Wassermann in some cases, it will not supplant that reaction but will afford an additional method of diagnosis.

ETIOLOGICAL FACTORS OF ACNE VULGARIS. ALBERT STRICKLER, p. 579.

Strickler believes in a disturbed gastro-intestinal state as a cause of acne and conducted some experiments with regard to the production of indol. Complement-fixation tests using colon bacillus antigen were also done, giving 63.1 per cent. positive cases with colon bacilli of acne patients, 32 per cent. positive with normal colon.

No definite results were obtained with anaphylactic food reactions. A few cases showed a low hemoglobin percentage, while hyperglycemia was frequently

present. Pelvic disturbances in the female, puberty and abnormal sexual life played varying rôles in the production of acne. The acne bacillis was found in forty-eight of fifty-seven cases studied and the writer thinks the vast majority of cases of acne are due to the presence of this organism.

VITILIGO AND SYPHILIS OF THE CENTRAL NERVOUS SYSTEM. E. MURRAY AUER, p. 592.

Attention is called to the association of vitiligo and syphilis, four cases being cited in which the infection was of long standing and involved the central nervous system. The writer states that the areas of vitiligo suggest a central rather than a peripheral nerve lesion on account of the symmetrical and segmental distribution.

(*Ibidem, November, 1917, 154, No. 5*)

THE COMPARATIVE VALUE OF THE WASSERMANN, THE COLLOIDAL GOLD AND OTHER SPINAL FLUID TESTS. E. M. HAMMES, p. 625.

Positive globulin is found most constantly in pathologic spinal fluid, but is merely an indication of inflammation. These fluids usually show some lymphocytosis, but the most accurate test employed was the colloidal gold test, which, however, gives no reaction with a normal spinal fluid. In the diagnosis of tabes and cerebrospinal syphilis, the colloidal gold test gives a typical curve in the syphilitic zone, although the two conditions cannot be differentiated by this method. The paretic curve is frequent and quite characteristic.

In doubtful meningitis cases the gold curve is probably of value as it usually occurs in high dilutions and it has also proved to be more delicate than the Wassermann, some spinal fluids giving a negative Wassermann but a syphilitic curve with colloidal gold. Antisyphilitic treatment rarely affects the gold test although it may be sufficient to change the Wassermann.

REPORT OF A CASE OF SCLERODERMA OF THE SKIN. A. S. ROBINSON, p. 657.

The author reviews the literature on these cases in connection with his own case, which is stated to be of a diffuse type following an injury to the hip and affecting areas which usually are not involved.

Thyroid medication improved her protein metabolism as well as producing a clinical change for a time. The disease areas showed some degenerative changes in the peripheral nerves.

ARCHIVES OF INTERNAL MEDICINE

(*August, 1917, 20, No. 2*)

Abstracted by R. C. JAMIESON, M.D.

RELATION OF PELLAGRA TO LOCATION OF DOMICILE IN SPARTAN MILLS, S. C., AND THE ADJACENT DISTRICT. J. F. SILER, P. E. GARRISON AND W. J. MACNEAL, p. 198.

In reviewing the work of the commission on pellagra, a typical mill village, Spartan Mills, was taken as an example of a location which had had pellagra for a long time. It was found that all new cases since 1914 in the village had developed while the persons were residing in the same house or next door to an active pellagrin. At the latest the disease developed within six months after such exposure. However, the spread of pellagra has been greatly restricted since a sewer system has been installed. They are more convinced than before that pellagra is a slowly spreading, infectious disease which attacks only a small per-

centage of the population in the immediate vicinity and is favored by unsanitary methods of sewage disposal. .

(*Ibidem, October, 1917, 20, No. 4*)

THE RELATION OF PELLAGRA TO LOCATION OF DOMICILE IN INMAN MILLS, INMAN, S. C. J. F. SILER, P. E. GARRISON AND W. J. MACNEAL, p. 521,

The village in this report was a more rural community than Spartan Mills with regard to sewage, water supply, etc., and did not develop pellagra until after 1911. New cases of the disease during the past three years have been found to develop as in other communities, namely, in the same house with or next door to pellagrins. Susceptibility would seem to be low here as only a small percentage has been attacked.

(*Ibidem, November, 1917, 20, No. 5*)

SERUM CHANGES FOLLOWING PROTEIN "SHOCK" THERAPY. W. F. PETERSEN, p. 716.

From the experiments described in his article Petersen believes that "the benefits of shock therapy do not depend on any single alteration in the reacting organism, but on a series of factors in which not only the serum antibody and ferment changes, but the leukocytosis, the fever and sweating and the increased lymph flow have a part, along with the important cellular changes which are as yet intangible."

(*Ibidem, December, 1917, 20, No. 6*)

FIVE GENERATIONS OF ANGIONEUROTIC EDEMA. J. R. CROWDER AND T. R. CROWDER, p. 840.

The authors review the literature on the subject and give a complete history of a family in which five generations were afflicted with the disease. The first generation had only one affected, the second had nine, the third twelve, the fourth had five and the fifth had only one out of six descendents. They consider it a distinct clinical entity, although only a symptom, heredity being the chief etiologic factor in their group cases, all of whom were in neuropathic families. Some deaths had occurred due to acute swelling in the throat or internal organs and the question of anaphylaxis would seem to offer more in the solution of the etiology.

MEDICAL RECORD

(*Sept. 29, 1917, 92, No. 13*)

Abstracted by C. C. TOMLINSON, M.D.

NONSPECIFIC PROTEIN TREATMENT OF PSORIASIS. ELEANOR VAN NESS-VAN ALSTYNE, p. 538.

The author reports four cases of psoriasis treated with subcutaneous injections of proteins prepared from alfalfa and millet seed. In preparing the protein the author used the method described in the *Medical Record,* Vol. 92, No. 3, p. 98.

There was an improvement of the general condition and of the specific lesions in all cases, the latter beginning in from two to five weeks from the beginning of treatment. No other local or general treatment was used. There was no local or general reaction resulting from the injections. The time required for a cure as given in two of the cases was three and a half and four months, respectively. From one to three injections were given a week.

CERTAIN TECHNICAL REFINEMENTS IN METHODS OF INTRAVENOUS INJECTION. John H. Stokes, p. 529.

The author describes in detail the technic of venepuncture and salvarsan administration. The different errors in technic are pointed out and their remedies given.

(*Ibidem, Oct. 20, 1917, 92, No. 16*)

REPORT OF TWO CASES OF MULTIPLE KELOIDS. J. E. Lopez-Silvero, p. 673.

THE MASTIC REACTION OF THE CEREBROSPINAL FLUID. E. R. Smith, p. 675.

The author describes the technic of the mastic test and tabularizes the results of a series of tests, together with the diagnosis and the results of other biologic and chemical tests on the same fluid. That this test will render the same information as the Lange colloidal test is the opinion of the author.

Correspondence

REPORTING OF ACCIDENTS FROM LOCAL ANESTHETICS

To the Editor:—The Committee on Therapeutic Research of the Council on Pharmacy and Chemistry of the American Medical Association has undertaken a study of the accidents following the clinical use of local anesthetics, especially those following ordinary therapeutic doses. It is hoped that this study may lead to a better understanding of the cause of such accidents, and consequently to methods of avoiding them, or, at least, of treating them successfully when they occur.

It is becoming apparent that several of the local anesthetics, if not all of those in general use, are prone to cause death or symptoms of severe poisoning in a small percentage of those cases in which the dose used has been hitherto considered quite safe.

The infrequent occurrence of these accidents and their production by relatively small doses point to a peculiar hypersensitiveness on the part of those in whom the accidents occur. The data necessary for a study of these accidents are at present wholly insufficient, especially since the symptoms described in most of the cases are quite different from those commonly observed in animals even after the administration of toxic, but not fatal, doses.

Such accidents are seldom reported in detail in the medical literature, partly because physicians and dentists fear that they may be held to blame should they report them, partly, perhaps, because they have failed to appreciate the importance of the matter from the standpoint of the protection of the public.

It is evident that a broader view should prevail, and that physicians should be informed regarding the conditions under which such accidents occur in order that they may be avoided. It is also evident that the best protection against such unjust accusations, and the best means of preventing such accidents consist in the publication of careful detailed records when they have occurred, with the attending circumstances. These should be reported in the medical or dental journals when possible; but when, for any reason, this seems undesirable, a confidential report may be filed with Dr. R. A. Hatcher, 414 East Twenty-Sixth Street, New York City, who has been appointed by the Committee to collect this information.

If desired, such reports will be considered strictly confidential so far as the name of the patient and that of the medical attendant are concerned and such information will be used solely as a means of studying the problem of toxicity of this class of agents, unless permission is given to use the name.

All available facts, both public and private, should be included in these reports, but the following data are especially to be desired in those cases in which more detailed reports cannot be made:

The age, sex, and general history of the patient should be given in as great detail as possible. The state of the nervous system appears to be of especial importance. The dosage employed should be stated as accurately as possible; also the concentration of the solution employed, the site of the injection (whether intramuscular, perineural or strictly subcutaneous), and whether applied to the mouth, nose, or other part of the body. The possibility of an injection having been made into a small vein during intramuscular injection or into the gums should be considered. In such cases the action begins almost at once, that is, within a few seconds.

The previous condition of the heart and respiration should be reported if possible; and, of course, the effects of the drug on the heart and respiration, as

well as the duration of the symptoms, should be recorded. If antidotes are employed, their nature and dosage should be stated, together with the character and time of appearance of the effects induced by the antidotes. It is important to state whether antidotes were administered orally, or by subcutaneous, intramuscular or intravenous injection, and the concentration in which such antidotes were used.

While such detailed information, together with any other available data, are desirable, it is not to be understood that the inability to supply such details should prevent the publication of reports of poisoning, however meager the data, so long as accuracy is observed.

The committee urges on all anesthetists, surgeons, physicians and dentists the making of such reports as a public duty; it asks that they read this appeal with especial attention of the character of observations desired.

TORALD SOLLMANN, Chairman.
R. A. HATCHER, Special Referee.

Therapeutic Research Committee of the Council on Pharmacy and Chemistry of the American Medical Association.

Book Reviews

DISEASES OF THE SKIN. By Richard L. Sutton, M.D., Professor of Diseases of the Skin, University of Kansas School of Medicine; Former Chairman of the Dermatological Section of the American Medical Association; Member American Dermatological Association; Assistant Surgeon United States Navy, Retired; Dermatologist to the Christian Church Hospital. With 833 illustrations and 8 colored plates. Second edition, revised and enlarged. *C. V. Mosby Company, St. Louis.* 1917.

The first edition of Sutton's admirable textbook appeared in 1916. The fact that it was necessary to print a second edition within a year shows that the work has received the recognition and success it deserves. The author has taken advantage of the opportunity and has added to the various subjects the important literature of 1916. Considerable new material has been added so that we find in the present edition the subjects of gangrenous balanitis, atrophy of the mucous membranes of the tongue and mouth, and atrophy of the fatty layer of the skin, which were wanting in the first edition. The article on perleche has been rewritten and that portion of the one on pediculosis which deals with treatment has been considerably amplified. One hundred and forty new illustrations and 100 pages of text have been added. The typographic errors of the first edition have been corrected. For the most part the illustrations are good, but the presswork is poor on a few of them in the reviewer's copy.

This profusely illustrated, thoroughly modern textbook of a thousand pages covers the entire subject of dermatology and syphilology in an admirable manner. We hope and believe that the second edition will be as enthusiastically received as was the first edition.

THE PRINCIPLES AND PRACTICE OF DERMATOLOGY. By William Allen Pusey, A.M., M.D., Professor Emeritus of Dermatology in the University of Illinois; Dermatologist to St. Luke's and Augustana Hospitals, Chicago; Member of the American Dermatological Association. Third edition. *D. Appleton & Company, New York and London.* 1917.

We welcome the third edition of this well-known textbook. The first edition was published in 1907, and the last (second edition) appeared in 1911. Dermatology and especially syphilology have grown considerably since the publication of the second edition, but we find that the author has kept pace with recent progress. The book has been thoroughly revised and brought up to date. The subject of syphilis has been entirely rewritten. The author, in this part of the book, elaborates considerably, and we are glad that he does because it serves to strengthen the belief that syphilology and dermatology are inseparable.

Another topic that has been completely rewritten is pellagra. Other subjects that have been added or rewritten are: changes of the blood in skin diseases, autoserum therapy, fulguration, infantile erythema, hair-dye dermatitis, dermatitis from formaldehyd, gonorrheal eruptions, balanitis gangrenosa, ulcus acutum vulvae, espundia, skin lesions produced by bees, ants, flies, gnats, etc., blue atrophy of the skin, dermatitis nodularis necrotica, dermatothalasia, nevus anemicus, zoniform ectases, purpura annularis telangiectodes, leukemia cutis, sarcoid, trichotillomania, Moeller's glossitis, periadenitis mucosa necrotica.

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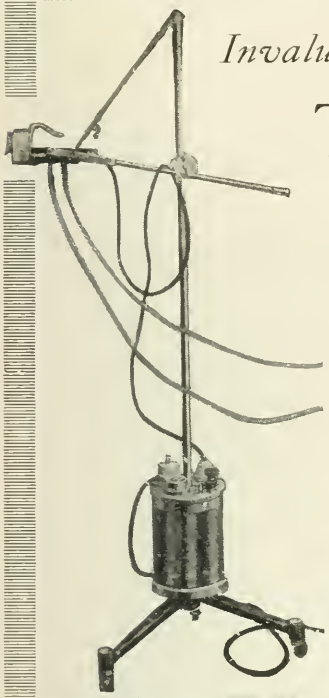

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